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Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,
Petitioners,

v.

STUART CIRCLE HOSPITAL CORPORATION,
Respondent.

On Petition For Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

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PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

The Employee Retirement Income Security Act of 1974 ("ERISA") preempts all state laws that relate to employee benefit plans, with a limited exception for laws that regulate insurance. The question presented in this case is:

Whether a state law that mandates only which health care providers must be included in a preferred provider organization used by an employee benefit plan to deliver health care services, but not what services must be provided to plan participants, is saved from preemption under ERISA because it regulates the "business of insurance."

LIST OF PARTIES

All parties are listed in the caption. Pursuant to Rule 29.1, petitioners Aetna Life Insurance Company and Aetna Health Management provides the following list of parent corporations and non-wholly owned subsidiaries: Aetna Life and Casualty Company, Med Southwest, Inc., HEALTHWAYS, Inc., Aetna Health Plans of San Diego, Inc., Aetna Health Plans of Colorado, Inc., PHPSNE Parent Corporation, Aetna Health Plans of Florida, Inc., and PARTNERS Health Plan of Pennsylvania, Inc.

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PETITION FOR WRIT OF CERTIORARI

Aetna Life Insurance Company and Aetna Health Management (collectively "Aetna") hereby petition this Court for a writ of certiorari to review the judgment in this case of the United States Court of Appeals for the Fourth Circuit.

OPINIONS AND ORDERS BELOW

The July 1, 1993 order of the Fourth Circuit denying Aetna's petition for rehearing and suggestion for rehearing in banc is unreported and is reproduced at App. 1a-2a. That court's June 2, 1993 opinion is

reported at 995 F.2d 500 and is reproduced at App. 3a-13a. The July 22, 1992 memorandum opinion of the United States District Court for the Eastern District of Virginia is unreported and is reproduced at App. 14a-32a.

JURISDICTION

The Fourth Circuit entered judgment in this case on June 2, 1993, and denied Aetna's timely petition for rehearing on July 1, 1993. This petition is being filed within 90 days of the denial of rehearing. This court has jurisdiction over this case pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The statutes involved in this case are the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, the McCarran-Ferguson Act, 15 U.S.C. § 1101 *et seq.*, and Virginia Code § 38.2-3407 (1993), the respective relevant provisions of which are set out at App. 33a-34a.

STATEMENT OF THE CASE

The preferred provider organization ("PPO") is a system by which employee benefit plans deliver health care to plan participants at a reduced cost. This case presents an important question whether ERISA's broad preemption of state laws "relating to" employee benefit plans nonetheless tolerates state regulation of the membership of PPOs because PPO membership constitutes the "business of insurance."

PPO administrators customarily contract with a limited network of "preferred" health care providers for

the provision of health care services to employee benefit plan subscribers at substantial discounts. The cost savings afforded by a PPO are made possible by ensuring increased patient volume for preferred providers. Employee benefit plan participants who choose PPOs are given financial incentives to use preferred rather than nonpreferred providers; participants typically are reimbursed for a greater percentage of the cost of treatment by a preferred provider. This practice results in a relatively greater number of patients for preferred providers. Increased patient volume allows the preferred providers to lower their per patient costs, which, in turn, permits the providers to discount their fees. Some limitation on PPO membership thus is necessary to enable the preferred providers to receive an increase in patient volume sufficient to warrant the reduction in fees. The broader the PPO network, the less likely it is that the preferred providers each will experience the necessary increase in patient volume.

The PPO arrangement itself is only a contract between a PPO administrator and health care providers. The contract does not address what health care services are covered under an employee benefit plan, but only the discounted fees that the providers will charge for treating plan participants. The PPO administrator may not even be an insurance company. The method by which a PPO is offered in an employee benefit plan may or may not involve a contract of insurance; the employer may purchase insurance to pay for the PPO service, or may pay the PPO costs as they are incurred.

Virginia Code § 38.2-3407 regulates the membership in PPOs offered or administered by an insurance com-

pany. Like similar laws in many other states, this "any willing provider" statute mandates that no health care provider willing to meet the terms and conditions of such a PPO may be excluded from the organization.[1] This proscription, on its face, applies even when the insurance company is acting only as administrator, and is not also insuring payment of covered services.

Aetna Life Insurance Company variously administers and insures employee benefit plans in the Richmond, Virginia area. Aetna Health Management maintains and manages the PPO that Aetna Life Insurance Company established in the Richmond area. Some of the employee health benefit plans subscribing to Aetna's Richmond-area PPO are self-insured; in those instances, Aetna provides only administrative services.

Respondent Stuart Circle Hospital Corporation ("Stuart Circle") owns and operates a hospital in Richmond, Virginia. Stuart Circle sued Aetna in Virginia state court, alleging that Aetna had violated section 38.2-3407 by excluding Stuart Circle from Aetna's Richmond-area PPO. Aetna removed the case to the United States District Court for the Eastern District of Virginia under 28 U.S.C. § 1441(a), on grounds of diversity of citizenship.

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[1] Several states have mandatory provider laws of exactly the same form as that in Virginia. Other states have mandatory provider laws restricting PPO administrators' ability to contract freely with health care providers. See *infra* at n.2. The Fourth Circuit's decision in this case implicates the enforceability of each of these laws as they relate to employee benefit plans.

The district court later granted Aetna's motion for summary judgment, holding that section 38.2-3407 is preempted by the ERISA. App. 32a. Concluding first that the Virginia statute "relates to" employee benefit plans within the meaning of section 514(a) of ERISA, the district court held also that the statute is not saved from preemption by ERISA's insurance savings clause, section 514(b)(2)(A), which excepts from preemption state laws that "regulate insurance." App. 24a, 31a-32a. The district court recognized that the question whether a state law "regulates insurance" under ERISA is to be determined by the same criteria used to establish whether a state law regulates the "business of insurance" under the McCarran-Ferguson Act. App. 24a. Relying primarily on this Court's decision in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), *cert. denied*, 469 U.S. 1160 (1985) the district court held that section 38.2-3407 does not regulate the "business of insurance," but only the business of insurance companies. In *Royal Drug*, the Court held that a service arrangement between a health insurer and a group of pharmacies that affected the insured indirectly by limiting available pharmacies is not the "business of insurance." Similarly, the district court here concluded that the PPO mechanism the Virginia statute regulates is merely a cost-saving arrangement between an insurer and service providers; it does not involve the transfer of risk between an insurer and an insured, the essence of the "business of insurance." App. 27a-29a.

A panel of the Fourth Circuit reversed. App. 3a-13a. Although agreeing that section 38.2-3407 "relates to" employee benefit plans, App. 7a, the Fourth

Circuit held that the Virginia statute is saved from preemption as a law that regulates the "business of insurance." App. 9a. Relying on *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), the Fourth Circuit first concluded that section 38.2-3407 regulates the "business of insurance" under a "common-sense" approach because it regulates, "albeit indirectly," "the relationship between insurer and insured [and] the type of policy which could be issued." App. 9a.

The Fourth Circuit held also that the Virginia statute regulates the "business of insurance" under the three criteria developed under the McCarran-Ferguson Act. According to the court, PPO arrangements have the effect of "transferring or spreading the policyholder's risk" that service will not be provided by the doctor or hospital of the policyholder's choice, PPOs are "an integral part of the policy relationship between the insurer and the insured," and the Virginia statue is "expressly 'limited to entities within the insurance industry.'" App. 9a-11a.

Aetna petitioned the Fourth Circuit for rehearing and suggested rehearing in banc. Aetna explained that the Fourth Circuit's decision is contrary to *Royal Drug* and to the Fourth Circuit's own decision in *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (1980), *cert. denied*, 450 U.S. 916 (1981). Following the rule of *Royal Drug*, the Fourth Circuit in *Virginia Academy* held that an insurance company practice of not reimbursing the cost of services from certain health care providers is not the "business of insurance," because it addresses only who provides covered services, not what health services are covered. 624 F.2d at 484.

On July 1, 1993, the Fourth Circuit denied Aetna's rehearing petition without further explanation. App. 1a-2a. On August 11, 1993, the district court granted Aetna's motion to stay proceedings in this case pending this Court's disposition of the petition for writ of certiorari.

REASONS FOR GRANTING THE WRIT

The question presented by this petition is of extraordinary importance. The Fourth Circuit adopted an improperly broad conception of the "business of insurance" under the ERISA insurance savings clause, and thereby let stand a Virginia law that undermines the economic value of the preferred provider organization, a vital element in the efficient delivery of employee health care. The PPO mechanism will work to lower the cost of health care only if the pool of providers in the organization is limited. The Virginia "any willing provider" statute eliminates the cost savings available through this efficient mechanism for delivering health care to employee benefit plans by mandating the inclusion of certain providers in PPO networks. The Fourth Circuit's decision accepts the present patchwork of state mandatory provider laws, to the serious detriment of employee benefit plan participants. The Virginia statute is precisely the type of costly state regulation that ERISA was intended to preempt. Federal authorities regularly have condemned such laws as anticonsumer and anticompetitive.

The Fourth Circuit's resolution of the key "business of insurance" issue is directly contrary to this Court's decision in *Royal Drug* and is inconsistent with the Third Circuit's recent decision in *Ticor Title Ins. Co.*

v. FTC, 998 F.2d 1129 (3d Cir. 1993). *Royal Drug* teaches that a practice constitutes the "business of insurance" only if it involves the underwriting of risk, and that an insurance company service arrangement that has only an indirect effect on insurance benefits is not the "business of insurance." *Ticor* is to the same effect. The Fourth Circuit failed to recognize the crucial distinction between the underwriting of risk and the much broader category of insurance company practices that may have some effect on the insured. The arrangement of a PPO is nothing more than a service contract between a PPO administrator and health care providers; it is not a contract of insurance, and does not affect the risk of treatment underwritten in a health insurance contract.

The Fourth Circuit's misapplication of ERISA preemption principles creates extraordinary costs for employee benefit plan participants. Supreme Court review is necessary to reverse this unfortunate ruling.

A. The Fourth Circuit's Decision Will Have Profound Adverse Consequences for the Efficient Delivery of Health Care, in Direct Contravention of the ERISA Mandate

By upholding state authority to regulate employee benefit plans in contradiction of ERISA's preemptive mandate, the Fourth Circuit's decision seriously impairs the efficient delivery of health care to employee benefit plan participants. ERISA preemption establishes employee benefit plan regulation "as an area of exclusive federal concern." *FMC Corp. v. Holliday*, 111 S. Ct. 403, 407 (1990). Recognizing that the "economic impact of [employee benefit plans] is increasingly interstate," and that the "soundness and stability of plans with respect to adequate funds to

pay promised benefits may be endangered," Congress in ERISA sought to relieve employee benefit plans of the inefficiencies of having to comply with often conflicting state regulation. See 29 U.S.C. § 1001(a); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987). Accordingly, under ERISA § 514(a), any state law that "relates to" an employee benefit plan gives way, unless it fits within one of the "very limited exceptions to preemption" contained in the ERISA savings clause, section 514(b). *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 104 (1983).

ERISA preempts not only state laws on subject matters covered by ERISA, but state laws that have any "connection with or reference to" an employee benefit plan. *Id.* at 96-97. ERISA preempts the field; where ERISA does not regulate a certain aspect of employee benefits, the area is to be free from regulation under both ERISA and state law. *Id.* at 98-99. The resulting "regulatory void" in certain areas evinces congressional intent to leave those subjects to the discretion of benefit plan designers and labor-management negotiations. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981). Thus, ERISA places few restrictions on the delivery of employee welfare benefits, like health care, allowing instead for broad ranging innovation and ready adaptation to changing circumstances. *See* 29 U.S.C. § 1051(1) (exempting welfare plans from participation and vesting requirements applicable to pension plans); 29 U.S.C. § 1081(1) (exempting welfare plans from funding requirements applicable to pension plans). "[M]edical insurance must take account of inflation, changes in medical practice and technology, and increases in the

costs of treatment independent of inflation." *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988).

The Fourth Circuit's decision in this case permits the very state regulation of employee health plans that ERISA preempts. The PPO is precisely the kind of market-driven health care innovation Congress encouraged through ERISA. Yet, state regulation of PPOs presently is a patchwork of requirements and prohibitions, with numerous states imposing different mandates on the providers that must be included in a PPO arrangement.[2] The diversity of this legislation

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[2] The requirements vary widely. Several states in addition to Virginia impose a requirement that any provider willing to meet the terms and conditions of the PPO must be allowed in the network. E.g., Ga. Code Ann. § 33-20-16 (1990); 215 Ill. Comp. Stat. Ann. 5/370h (1993); Ind. Code Ann. § 27-8-11-3 (Burns 1992); La. Rev. Stat. Ann. § 40:2202 (West 1992); Utah Code Ann. § 31A-22-617 (1991); Wyo. Stat. § 26-22-503 (1977). The any willing provider requirements in some states apply to all health care providers, while in other states the law is limited to physicians only, excluding institutional providers. E.g., 215 Ill. Comp. Stat. Ann. 5/370h; La. Rev. Stat. Ann. § 40:2202. In still other states, the law applies only to pharmacy arrangements. E.g., Ala. Code § 27-45-3 (Supp. 1993); Idaho Code § 41-1844 (1991); S.D. Codified Laws Ann. § 58-18-37 (1990); Wis. Stat. Ann. § 628.36 (1991 & Supp. 1992). Numerous states mandate inclusion of certain types of providers (e.g., chiropractors, podiatrists) in PPOs. E.g., Neb. Rev. Stat. § 44-4112 (1988); Nev. Rev. Stat. Ann. §§ 695C.177, 695C.178 (1986); W.Va. Code § 33-25A-31 (1992). Overlaid on these disparate statutory requirements are regulations in the various states that may impose additional requirements or otherwise give specific meaning to the often indeterminate language of statutes. E.g., Ark. Ins. Comm. Bulletin 9-85 & 9-85A (1985) (interpreting Arkansas statute as an any willing provider law). State court decisions in-

is the result of successful lobbying efforts by service providers seeking inclusion in PPOs. Elizabeth S. Rolph, et al., *State Laws and Regulations Governing Preferred Provider Organizations* 38-40 (Rand 1986). Employee benefit plan administrators, who frequently administer plans that operate across state lines, must conform their contractual arrangements to the requirements of these myriad states laws.

This panoply of regulation has a profound effect on the operation of employee benefit plans. In 1992, nearly 40 percent of all employers nationwide offered their employees some form of PPO; almost 58 million employees and their dependents participated in these programs. American Association of Preferred Provider Organizations, "PPO Growth" (1993). Requiring PPO administrators to conform to overabundant state regulation will increase costs, and those costs will be felt by this multitude of employee benefit plan participants. It is to avoid just this result that ERISA preempts state regulation of benefit plans:

> A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Pre-emption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations.

Fort Halifax, 482 U.S. at 11.

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terpreting statutes and regulations also add to the multiple diverse rules to which employee benefit plan sponsors must adhere.

Beyond the inefficiencies of compliance with such a "patchwork scheme of regulation," the substance of the any willing provider laws that the Fourth Circuit decision affirms would be costly for employee benefit plan participants even if all states had identical laws. The key to the PPO arrangement is the substantial cost discounts made possible by the limitation of providers in the organization. Providers are able to reduce their fees for services offered through the PPO because the limited size of the PPO insures each provider a sufficient volume of patients to warrant the fee reductions. Increased patient volume from a single PPO creates economies of scale, reduces marketing costs, and reduces transaction costs as providers deal with fewer third-party payors. Limited PPO panels also reduce costs to the PPO administrator by lowering administrative costs and making possible more efficient utilization and peer review programs by which sponsors monitor provider behavior. *See* Rolph, et al., *supra* at 46-47; *Report to Health Insurance Association of America: Cost Analysis of State Legislative Mandates on Six Managed Health Care Practices* 14-26 (Wyatt Co. 1991). Employee health plan participants benefit from all of these savings.

Limited-membership PPOs also reduce costs and improve services by creating competition between providers. When PPO administrators are able to negotiate freely with service providers, they can create more efficient PPO arrangements and more favorable terms for plan participants by placing providers in competition for inclusion in the PPO. *See* Lori A. Tobias, *Cost v. Quality in the Regulation of Preferred Provider Arrangements: A "Green Light to the Gold Rush"?*, 41 Sw. L.J. 1155, 1187-1190 (1988); G.A.

Melnick, et al., *The Effects of Market Structure and Bargaining Position on Hospital Prices*, 11 J. Health Econ. 217 (1992). Moreover, the existence of multiple limited-size PPO plans gives a choice to the consumers of such plans. The resulting competition reduces costs and spurs innovation:

> The most important feature of the plans in stimulating competition is that they distinguish between specific sets of physicians and hospitals, with a separate premium for each. The consumer picking the more efficient set of providers is rewarded by a lower premium and/or greater benefits. The attractive and efficient provider groupings are regarded by enrollment growth. In this way incentives for cost consciousness on the part of providers and consumers are created.

Jon B. Christianson & Walter McClure, *Developing a Regulatory Strategy Consistent with a Competitive Health Care System*, in *Socioeconomic Issues of Health* 104 (Douglas E. Hough & Glen I. Misek eds., 1980). *See also* David Dranove, et al., *Is Hospital Competition Wasteful?*, 23 RAND J. Econ. 247 (Summer 1992).

The forced expansion of PPO provider membership through any willing provider laws undermines all of these salutary effects and increases dramatically both the cost of administration and the cost of claims made by employee benefit plan participants. A 1991 study by the Wyatt Company estimated that any willing provider laws increase PPO administrative costs between 34 and 52 percent, and increase the cost of claims between 8.8 and 14.2 percent. *Report to Health*

Insurance Association of America at 15-16, 19-20. The study concluded that if a large number of providers choose to join a PPO pursuant to any willing provider legislation, the "legislative mandate would eliminate the value of the PPO to the community." *Id.* at 5. It is, consequently, not surprising that a 1986 survey of PPO sponsors found that mandatory provider laws posed the most serious of all possible regulatory threats to the effective operation of PPOs. Elizabeth S. Rolph, Paul B. Ginsburg & Susan D. Hosek, *The Regulation of Preferred Provider Organizations*, 6 Health Affairs 32, 40 (Fall 1987).

Any willing provider laws also impair competition between service providers, to the detriment of consumers. The Federal Trade Commission has for over a decade objected to mandatory provider laws as anticompetitive and anticonsumer. Attached (App. 35a-43a) is a recent letter from the Acting Director of the FTC's Office of Consumer and Competition Advocacy to the Attorney General of the State of Montana.[3] The letter details the FTC's objections to Montana's any willing provider statute, reaffirming all of the cost and competition effects discussed above. (The Montana mandatory provider law, which was allowed to sunset in July of this year, is virtually identical to the Virginia law at issue here.) The Acting Director explains the competitive importance of limited-provider panels and the anticompetitive, anticonsumer effect of any willing provider requirements. The letter also describes the FTC's long-standing public objection—including congressional testimony, com-

[3] Petitioners ask the Court to take judicial notice of this matter of public record.

ment letters to state legislators and agencies, and litigation[4]—to efforts to suppress selective contracting with a limited panel of health care providers. App. 36a-37a. The FTC's opposition to any willing provider laws underscores the importance of the issue in this case to health care consumers.

B. The Fourth Circuit's Decision is Directly Contrary to Supreme Court Authority and Is Inconsistent with the Third Circuit's Recent Decision in *Ticor Title Ins. Co. v. FTC*

The ERISA insurance savings clause saves from preemption any state law "which regulates insurance." 29 U.S.C. § 1144(b). Whether a practice constitutes "insurance" under ERISA is determined by the same criteria used to determine the "business of insurance" saved from federal antitrust regulation under the McCarran-Ferguson Act. *Pilot Life*, 481 U.S. at 48-49; *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1983).[5] The Virginia mandatory

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[4] The FTC has instituted a series of law enforcement actions to prevent private anti-competitive arrangements that suppress or eliminate selective contracting. See, e.g., *Medical Service Corp. of Spokane County*, 88 F.T.C. 906 (1976); *American Medical Association*, 94 F.T.C. 701 (1979) *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court*, 455 U.S. 676 (1982); *Eugene M. Addison, M.D.*, 111 F.T.C. 339 (1988). See generally App. 36a-37a. These private arrangements have the same effect as any willing provider laws.

[5] The ERISA insurance savings clause and the McCarran-Ferguson Act each carves out an exception to federal regulation for the "business of insurance," leaving the regulation of such activity to the states. *Metropolitan Life*, 471 U.S. at 744 n.21. Because the two statutes "utilize similar language to define what is left to the States," the Court has treated the definition of the "business of insurance" as essentially the same under ER-

provider statute regulates the contractual relationship between PPO administrators and medical service providers. The Fourth Circuit held that these service contracts constitute the "business of insurance," and therefore that the Virginia statute is excepted from ERISA preemption. The court thereby contravened controlling Supreme Court authority on the "business of insurance," and placed itself in conflict on this issue with the Third Circuit.

1. The Fourth Circuit Failed to Heed the Lesson of *Royal Drug* that the Selection of Service Providers Is Not the "Business of Insurance."

The key to the "business of insurance" is the underwriting of risk. *SEC v. Variable Annuity Life Ins. Co.*, 359 U.S. 65, 73 (1959) ("underwriting of risks [is] the one earmark of insurance"). With health insurance, that risk is the treatment of illness or injury. A PPO, on the other hand, is a noninsurance contractual arrangement that deals only with *who* will provide treatment for the injury or illness covered by an employee benefit plan, and not what services are covered. It is a way of organizing the efficient delivery of medical benefits that is completely independent of the risk that a benefit plan participant will be reimbursed for the treatment of any particular illness or injury.

The Fourth Circuit failed to recognize the crucial distinction between the underwriting of risk and the much broader category of insurance company practices that may have some effect on the insured. Specifically, the court held that the "several components

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ISA and McCarran-Ferguson. *Id.* at 742-44 & n.21; *Pilot Life*, 481 U.S. at 48-49.

to the 'policyholder's risk'" include the risk of not being able to use the health care provider of the policyholder's choice." App. 9a-10a. The court explained that, by expanding the pool of available providers (at least in theory), the Virginia statute forces insurers to underwrite more of this risk. App. 10a. Therefore, according to the Fourth Circuit, the statute regulates the "business of insurance," even though this element of "risk" has nothing to do with whether a benefit plan provides coverage for the treatment of any particular illness or injury.

That conclusion is directly contrary to this Court's decision in *Royal Drug*. The precise issue in that case, as in this one, was whether a limitation on the preferred *providers* of a medical service, without a limitation on covered *services*, constitutes the business of insurance. The Court held that cost-saving arrangements that restrict the provider of services, but not the services rendered, are not the "business of insurance."

In *Royal Drug*, a Blue Shield insurance company offered policies entitling the insured to purchase prescription drugs for $2 from any pharmacy participating in a "Pharmacy Agreement" with Blue Shield. Participating pharmacies were required to sell drugs to Blue Shield's policyholders for $2, and were reimbursed only for their cost in acquiring the drug. The arrangement was, in essence, a PPO for pharmacies.

A group of independent pharmacists brought an antitrust action against Blue Shield, which defended on the ground that the pharmacy agreements qualified as the "business of insurance" under the McCarran-Ferguson Act and therefore were exempt from the federal antitrust laws. The Court concluded that the

agreements did not constitute the "business of insurance" because they did not have the effect of transferring or spreading a policyholder's risk. 440 U.S. at 214. The agreements served "only to minimize the costs Blue Shield incurs in fulfilling its underwriting obligations," *id.* at 213, and while "[s]uch cost-savings arrangements may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums . . . they are not the 'business of insurance.'" *Id.* at 214.

Much like respondents here, petitioners in *Royal Drug* argued that the Pharmacy Agreements constituted the "business of insurance" because they "closely affect" the insurance contract. 440 U.S. at 216. That argument "proves too much," however. *Id.* By that way of thinking, the Court explained, any business decision by an insurance company that may affect the insurance contract would constitute the "business of insurance." The McCarran-Ferguson Act (and consequently ERISA) exempts the "business of insurance," not the "business of insurance companies." *Id.*

The present case is legally indistinguishable from *Royal Drug*. Aetna's PPO arrangements are cost-saving measures independent of the relationship between insurer and insured; they are contracts between Aetna and service providers, exactly like the Pharmacy Agreements in *Royal Drug*. Those service contracts do not involve the underwriting of risk, and therefore do not constitute the "business of insurance."

The Fourth Circuit nonetheless maintained that PPO arrangements have the effect of "transferring or spreading the policyholder's risk" that service will

not be provided by the doctor or hospital of the policyholder's choice. App. 10a. This Court rejected a similar assertion from petitioners in *Royal Drug*. The Court made clear that such service contracts do not affect a policyholder's "risk":

> The fallacy of the petitioners' position is that they confuse the obligations of Blue Shield under its insurance policies, which insure against the risk that policyholders will be unable to pay for prescription drugs during the period of coverage, and the agreements between Blue Shield and the participating pharmacies . . . . The benefit promised to Blue Shield policyholders is that their premiums will cover the cost of prescription drugs except for a $2 charge for each prescription.

440 U.S. at 213-24. The benefit promised plan participants in this case is that treatment for illness and injury will be paid for at a prescribed rate, not that they will be able to use any doctor or hospital.[6]

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[6] This Court's recent decisions in *United States Dept. of Treasury v. Fabe*, 113 S. Ct. 2202 (1993), and *Hartford Fire Ins. Co. v. California*, 113 S. Ct. 2891, *cert. denied sub nom.* 113 S. Ct. 3034 (1993), reaffirm *Royal Drug* and emphasize the Fourth Circuit's misapplication of Supreme Court authority. In *Fabe*, the Court held that an Ohio law specifying the priority of claims in proceedings to liquidate an insurance company regulated the "business of insurance" because the statute affected directly the payment of the contracted for insurance benefits. The Court distinguished *Royal Drug*, explaining that the service contracts at issue there were "ancillary activities" with insufficient connection to the obligations of the insurance contract. *Id.* at 2209. So, too, are PPO arrangements.

In *Hartford Fire*, the Court reaffirmed the distinction be-

The Fourth Circuit attempted to distinguish *Royal Drug* on the ground that "[t]he practice at issue in *Royal Drug*, unlike Aetna's PPO, did not restrict the availability of benefits to insureds because any pharmacy which agreed to the insurance company's terms was allowed to participate." App. 12a. The factual premise is incorrect. The practice at issue in *Royal Drug* clearly *did* restrict the availability of benefits to the insured, because not all pharmacies were willing to meet the price requirements necessary to participate—hence the lawsuit. More important, this Court made clear in *Royal Drug* that the open access of pharmacies to the Pharmacy Agreements was irrelevant to its decision. The result would be the same, the Court explained, if "an insurance company entered into a contract with a large retail drug chain whereby its policyholders could obtain drugs under their policies only from stores operated by this chain." 440 U.S. at 215. Such an arrangement, which would require the policyholder to "shoulder all or part th[e] cost when seeking [drugs] from an excluded [pharmacy] of his or her choice," App. 10a, is not the

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tween the "business of insurance" and the "business of insurance companies": " 'the business of insurance' should be read to single out one activity from others, not to distinguish one entity from another." 113 S. Ct. at 2901. Regarding insurance company contracts, the Court explained that "agreements that insurance companies ma[k]e with 'parties wholly outside the insurance industry,' . . . such as the retail pharmacists involved in *Royal Drug* . . . are unlikely to be about anything that could be called 'the business of insurance,' as distinct from the broader " 'business of insurance companies.' " *Id.* at 2902 (quoting *Royal Drug*, 440 U.S. at 232, 233). The arrangement of a PPO is a contract with medical service providers independent of insurance; it does not become the "business of insurance" because it is engaged in by an insurance company.

"business of insurance." A fortiori, the arrangement at issue in this case, which also might require the policyholder to "shoulder" the cost of seeking treatment from a doctor or hospital not included in Aetna's PPO, is not the "business of insurance."

The Fourth Circuit concluded that it could disregard *Royal Drug* because this Court did not rely on *Royal Drug* in *Metropolitan Life*. App. 12a. *Metropolitan Life* is, however, clearly distinguishable from *Royal Drug* and this case. *Metropolitan Life* involved a Massachusetts law that mandated insurance coverage for the treatment of mental illness. The Court held that this mandatory *benefit* law regulated the "business of insurance" under the ERISA insurance savings clause precisely because the law affected the insured's risk of treatment by mandating the health services covered. 471 U.S. at 743. This case involves a mandatory *provider* law fundamentally different from the mandatory benefit law at issue in *Metropolitan Life* and identical in all material respects to the mandatory provider arrangement in *Royal Drug*. A mandatory benefit law specifies the health care coverage that must be included in an insurance contract. Mandatory provider laws, on the other hand, say nothing about required services, but specify only who must be paid if certain services are covered.

By reading the "business of insurance" to include essentially all insurance company activity that somehow affects the insured, in contravention of Supreme Court authority, the Fourth Circuit's decision opens the door to inconsistent and inefficient state regulation of a wide variety of benefit plan cost-saving measures. *All* insurance company contracts with sup-

pliers of goods and services affect the costs associated with employee benefit insurance programs. The great danger of the Fourth Circuit's decision is that it allows stifling state regulation not only of PPOs, but of health maintenance organizations ("HMOs"), point-of-service arrangements, and a host of yet undeveloped mechanisms for the efficient delivery of health care. That is why ERISA preempts state laws that do not directly regulate the underwriting of risk. Moreover, the Fourth Circuit's unwarranted expansive definition of the "business of insurance" also may insulate from federal antitrust regulation the practices mandated by any willing provider laws, despite their undeniable anticompetitive and anticonsumer consequences.[7]

2. The Fourth Circuit's Decision Is in Conflict with the Third Circuit's Decision in *Ticor* in Its Reading of the "Business of Insurance."

The Fourth Circuit's overly-broad conception of the "business of insurance" is in clear conflict with the understanding of the Third Circuit in *Ticor Title Ins. Co. v. FTC*, 998 F.2d 1129 (3d Cir. 1993). That case, on remand from this Court, involved an antitrust challenge to certain title insurance company practices concerning title search and examination services. The Third Circuit concluded that these practices are not immune from antitrust scrutiny pursuant to the McCarran-Ferguson Act because title search and examination services performed by or for a title insur-

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[7] Because the definition of the "business of insurance" is identical under ERISA and the McCarran-Ferguson Act, the construction of that phrase adopted in a case under one statute is relevant to both. *Metropolitan Life*, 471 U.S. at 742-44; *Pilot Life*, 481 U.S. at 48-49.

ance company are not themselves the "business of insurance."

The "critical fact" supporting the Third Circuit's determination was that this service arrangement "does not itself spread or transfer risk." *Id.* at 1134. The Third Circuit found title search and examination analogous to the Pharmacy Agreements in *Royal Drug*, in that it has nothing to do with the actual performance of the insurance contract. *Id.* at 1136.[8] That title search might have an indirect effect on the course of conduct between the insurance company and insured is insufficient to bring the practice within the "business of insurance": "Following the lead of *Royal Drug*, we too reject the notion that the indirect effects of the title search and examination process on the business of title insurance are sufficient to merit protection from antitrust liability under section 2(b)." *Id.* at 1137. This conclusion is in stark contrast to the Fourth Circuit's holding in this case that the Vir-

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[8] In this regard, the Fifth Circuit's recent decision in *Tingle v. Pacific Mutual Ins. Co.*, 996 F.2d 105 (1993), is consistent with *Ticor* and *Royal Drug*, and inconsistent with the Fourth Circuit's decision in this case. The *Tingle* court held that a Louisiana law regarding representations made in health insurance applications is preempted by ERISA because it "relates to" employee welfare plans, and is not saved as a law that "regulates insurance." Acknowledging that the state law regulates insurance practices, and that it might fit a common-sense definition of the regulation of insurance, the court nonetheless concluded that the law does not regulate the "business of insurance" because it does "not act to spread policyholder risk." *Id.* at 108. "[T]he statute . . . does not spread the risk of insurance (health) coverage for which the parties contracted." *Id.* The same is true of the PPO, which does not affect the insured's risk of treatment for illness or injury.

ginia statute regulates the business of insurance because it affects the insurer-insured relationship, "albeit indirectly." App. 9a.

In short, the PPO arrangements at issue here are legally indistinguishable from the Pharmacy Agreements at issue in *Royal Drug*, and analogous to the title search and examination services at issue in *Ticor*. The result in all three cases should have been the same.

C. The Issue in This Case is Too Important to Wait for a Direct Split of Lower Court Authority

The Fourth Circuit declared that its decision regarding the "business of insurance" is consistent with decisions from two state courts and the Tenth Circuit regarding mandatory provider laws. App. 13a. None of those decisions can be reconciled with *Royal Drug* however.[9] They are further evidence of the dangerous

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[9] The statute at issue in *Blue Cross and Blue Shield of Kansas City v. Bell*, 798 F.2d 1331 (10th Cir. 1986), mandated payment for the services of particular types of health care providers. In holding that the statute regulates the "business of insurance," the Tenth Circuit made the same error as the Fourth Circuit here: the court there concluded that choice of provider is part of the transferred risk in a health insurance contract. *Id.* at 1335.

Blue Cross Hospital Service of Missouri v. Frappier, 698 S.W.2d 326 (Mo. 1985), also involved a statute requiring insurers to cover the services of particular types of providers, and to reimburse the cost of drugs from pharmacists whether or not they have a contract with the insurer. The Missouri Supreme Court misunderstood *Royal Drug* when it declared that there is no distinction between the mandated benefit provisions in *Metropolitan Life* and mandated provider statutes. The pharmacy provision in *Frappier*, in particular, regulates precisely the same

misunderstanding abroad about the "business of insurance" that this Court should set right.

The Fourth Circuit went to great lengths to avoid a conflict with these cases. In doing so, the court not only fundamentally misread *Royal Drug*, but it failed even to cite a prior Fourth Circuit decision directly on point. In *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981), an organization of clinical psychologists brought a Sherman Act antitrust suit against two Blue Shield health benefit plans based upon the plans' failure to pay for services rendered by certain psychologists. The Fourth Circuit concluded that the defendants' conduct was not the "business of insurance." Following *Royal Drug*, the Fourth Circuit in *Virginia Academy* explained that the "business of insurance" involves the risk that the insured will receive certain services, not the risk that the insured will receive service from a particular provider: "[The Blue Shield] decision regarding psychologists was not *whether* to underwrite the risk of those disorders or even the need for psychotherapy; rather it was a question of *who* they would pay for such services. The coverage remained the same." 624 F.2d at 484 (emphasis added). The Virginia statute at issue in this case also does not

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activity at issue in *Royal Drug*.

Blue Cross and Blue Shield of Virginia v. St. Mary's Hospital of Richmond, 245 Va. 24, 426 S.E.2d 117 (1993), presented exactly the same question as this case relevant to the same Virginia statute. The Virginia Supreme Court relied entirely on *Metropolitan Life* with little analysis. The court did not recognize that the Virginia statute is not a mandatory benefits law, and did not cite or discuss *Royal Drug*.

purport to regulate *whether* an insurance company must pay for the treatment of any illness or injury, but only *who* the insurance company must pay for such services.

That the Fourth Circuit in this case ignored completely *Virginia Academy*, despite copious citation by petitioners, in order to come in line with other courts is one indication that a split of authority may never arise on the precise issue in this case. Without guidance from this Court, other courts confronting mandatory provider laws can be expected to fall in line. In the meantime, as courts continue to apply an improper conception of the "business of insurance," employee benefit plans in Virginia and elsewhere will be prevented from responding efficiently to soaring health care costs, and benefit plan participants will suffer because of anticompetitive any willing provider laws. The issue is too important to wait for a lower court finally to get it right.

CONCLUSION

For the foregoing reasons, the Court should grant this petition and set the case for plenary review.

September 29, 1993

Respectfully submitted,

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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 92-1964
CA-91-736

STUART CIRCLE HOSPITAL CORPORATION
Plaintiff-Appellant

v.

AETNA HEALTH MANAGEMENT; AETNA LIFE INSURANCE COMPANY
Defendants-Appellees

HCA HEALTH SERVICES OF VIRGINIA
Amicus Curiae

FILED
July 1, 1993

On Petition for Rehearing with Suggestion for Rehearing In Banc

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The appellees' petition for rehearing and suggestion for rehearing in banc were submitted to this Court. As no member of this Court or the panel requested a poll on the suggestion for rehearing in banc, and

As the panel considered the petition for rehearing and is of the opinion that it should be denied,

IT IS ORDERED that the petition for rehearing and suggestion for rehearing in banc are denied.

For the Court,

/s/ Bert M. Montague
CLERK

APPENDIX B

UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

No. 92-1964

STUART CIRCLE HOSPITAL CORPORATION,
Plaintiff-Appellant,

v.

AETNA HEALTH MANAGEMENT; AETNA LIFE INSURANCE COMPANY,
Defendants-Appellees.

HCA HEALTH SERVICES OF VIRGINIA,
Amicus Curiae.

Appeal from the United States District Court for the Eastern District of Virginia, at Richmond. Richard L. Williams, Senior District Judge. (CA-91-736)

Argued: March 2, 1993

Decided: June 2, 1993

Before BUTZNER, Senior Circuit Judge. VOORHEES, Chief United States District Judge for the Western District of North Carolina, sitting by designation, and SPENCER, United States District Judge for the Eastern District of Virginia, sitting by designation.

Vacated and remanded by published opinion. Senior Judge Butzner wrote the opinion, in which Chief Judge Voorhees and Judge Spencer joined.

COUNSEL

ARGUED: Peter B. Edelman, KECK, MAHIN & CATE, Washington, D.C., for Appellant. William Jeffrey Kilberg, GIBSON, DUNN & CRUTCHER, Washington, D.C., for Appellees. **ON BRIEF:** Philip L. O'Neill, KECK, MAHIN & CATE, Washington, D.C., William R. Rakes, J. Scott Sexton, GENTRY, LOCKE, RAKES & MOORE, Roanoke, Virginia, for Appellant. Paul Blankenstein, Jeffrey T. Gilleran, GIBSON, DUNN & CRUTCHER, Washington, D.C.; John B. McCammon, Laura G. Fox, WRIGHT, ROBINSON, MCCAMMON, OSTHIMER & TATUM, Richmond, Virginia, for Appellees. William D. Iverson, William J. Shieber, COVINGTON & BURLING, Washingtgon, D.C., for Amicus Curiae.

OPINION

BUTZNER, Senior Circuit Judge:

Stuart Circle Hospital Corporation appeals the district court's grant of summary judgment against it and in favor of Aetna Health Management and Aetna Life Insurance. *See Stuart Circle Hospital Corp. v. Aetna Health Management*, 800 F. Supp. 328 (E.D. Va. 1992). The Hospital alleges that the district court erred by holding that Virginia Code § 38.2-3407, which prohibits insurance companies from unreasonably discriminating in establishing preferred provider organizations (PPOs), is unenforceable because it is preempted by Section 514(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1144(a). We review the district court's decision de novo. *Higgins v. E.I. DuPont*, 863 F.2d 1162, 1167 (4th Cir. 1988). Because we conclude that ERISA's insurance savings clause, 28 U.S.C. § 1144(b)(2)(A), exempts the Virginia statute from the application of ERISA's preemption clause, we vacate the judgment of the district court and remand the case for further proceedings.

I

To establish an insurer's PPO, an insurance company contracts with hospitals, doctors, and other health care providers for reduced charges. The insurer encourages utilization of these providers by its insureds. Although insureds may use providers other than those which participate in the PPO, they generally must pay a higher fee for the service rendered, as well as be reimbursed at a lower rate.

Virginia regulates the selection of an insurance company's preferred providers by Virginia Code § 38.2-3407:

> A. One or more insurers may offer or administer a health benefit program under which the insurer or insurers may offer preferred provider policies or contracts that limit the numbers and types of providers of health care services eligible for payment as preferred providers.
>
> B. Any such insurer shall establish terms and conditions that shall be met by a hospital, physician or type of provider listed in § 38.2-3408 in order to qualify for payment as a preferred provider under the policies or contracts. These terms and conditions shall not discriminate unreasonably against or among such health providers. No hospital, physician or type of provider listed in § 38.2-3408 willing to meet the terms and conditions offered to it or him shall be excluded.
>
> * * *
>
> E. For the purposes of this section, "preferred provider policies or contracts" are insurance policies or contracts that specify how services are to be covered when rendered by preferred and nonpreferred classifications of providers.

This section is one of several statutes found in chapter 34 of the Virginia Code, §§ 38.2-3400 to 38.2-3430, relating to accident and sickness insurance.

In early 1987, Aetna established a PPO in Richmond. Aetna markets its PPO only to employee benefit plans. The hospitals which Aetna selected as providers for its PPO were the same hospitals that were already participating in Aetna's health maintenance organization, HMO CHOICE. Aetna did not designate Stuart Circle Hospital to be one of its PPO provider facilities, although Stuart Circle was willing to meet Aetna's terms.

The Hospital brought this action, alleging that Aetna had failed to comply with Va. Code § 38.2-3407 by excluding it from participation in the Aetna PPO. In its defense, Aetna asserted that the Virginia statute is preempted by ERISA. The district court found that the Virginia statute affects employee benefit plans by regulating the structure of an insurer's PPO. 800 F. Supp. at 331-32. It therefore decided that because the Virginia statute relates to employee benefit plans, ERISA preempts the statute unless it is saved from preemption by the insurance clause. 800 F. Supp. at 333. Concluding that the Virginia statute regulated the business of an insurance company, and not the business of insurance, the district court held that ERISA preempted it. 800 F. Supp. at 333-37. The court granted summary judgment for Aetna, and Stuart Circle appealed.

II

Title 29 U.S.C. § 1144(a) provides that ERISA preempts state laws that "relate to any employee benefit plan," unless the laws are exempted. From time to time the Supreme Court has emphasized the breadth of ERISA's preemption provision. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138-42 (1990) (citing cases). It has stated that the "relates to" language should be given its broad

common-sense meaning so as to displace state laws which even indirectly concern themselves with employee benefits plans. Pointing out that "the key to [ERISA's preemption clause] is found in the words 'relate to,' " the Court reiterated that a state law may be preempted even though it does not address "the specific subjects covered by ERISA." *Ingersoll-Rand,* 498 U.S. at 138. The Court has delineated the breadth of the preemption clause by the statement: "A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). It is not surprising, therefore, that the Court has "virtually taken it for granted that state laws which are specifically designed to affect employee benefit plans are preempted. . . ." *Mackey v. Lanier Collection Agency,* 486 U.S. 825, 829 (1988) (citations and internal quotation marks omitted).

We agree with the district court that, contrary to the Hospital's contentions, Va. Code § 38.2-3407 relates to employee benefit plans.

The Virginia statute states that it applies to "health benefit program[s]" operated by insurers. Additionally, it has at its core a provision relating to the benefits which an insured may receive from an insurer's PPO. The statute restricts the ability of an insurance company to limit the choice of providers that otherwise would confine the participants of an employee benefit health plan to those preferred by the insurer. To be sure, a participant can select a provider outside the plan, but only at the expense of forfeiting some of his or her benefits. We conclude that 29 U.S.C. § 1144(a) preempts Va. Code § 38.2-3407 unless ERISA's insurance savings clause applies.

III

ERISA's insurance savings clause, 29 U.S.C. § 1144(b)(2)(A), provides that "nothing in this subchapter

shall be construed to exempt or relieve any person from any law of any State which regulates insurance. . . ." The effect of the clause is to save state laws governing the business of insurance from preemption that would otherwise occur by application of 29 U.S.C. § 1144(a). The Hospital argues that this savings clause exempts Va. Code § 38.2-3407 from ERISA preemption because the Virginia statute regulates the business of insurance. Aetna contends, and the district court held, that the Virginia statute is not saved from preemption because it regulates the non-insurance business of insurance companies.

In *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724 (1985), the Supreme Court addressed the savings clause in the context of determining whether a state statute which mandated a minimum level of psychological benefits regulated insurance and was thus saved from ERISA preemption. The Court approached its task by employing a two-part analysis. First, the Court took a "common-sense" approach, finding that the statute at issue regulated insurance contracts and thus logically should be encompassed by the "which regulates insurance" language of the savings clause. *Metropolitan Life,* 471 U.S. at 740-41. Second, the Court examined the case law which interpreted the phrase "business of insurance" with respect to the McCarran-Ferguson Act, 15 U.S.C. § 1011 et. seq. To illustrate that Massachusetts' mandated benefit law was a regulation of the business of insurance and, therefore, not preempted by ERISA, the Court reiterated:

> Congress was concerned [in the McCarran-Ferguson Act] with the type of state regulation that centers around the contract of insurance. . . . The relationship between insurer and insured, the type of policy which could be issued, its reliability, its interpretation, and enforcement—these were the core of the "business of insurance." [T]he focus [of the statutory term] was on the relationship between the insurance company and the policy-

> holder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the "business of insurance."

Metropolitan Life, 471 U.S. at 743-44 (emphasis deleted) (*quoting SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969)).

The Court also referred to criteria for interpreting the scope of the McCarran-Ferguson Act set forth in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982):

> *first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.

Metropolitan LIfe, 471 U.S. at 743.

Applying these standards, we conclude that Va. Code § 38.2-3407 regulates the business of insurance. It is part of a comprehensive code regulating accident and sickness insurance. The statute regulates the "relationship between insurer and insured [and] the type of policy which could be issued." 471 U.S. at 744. It prohibits an insurer's unreasonable restriction of the insured's choice of physician and hospital. To borrow the Court's phrase, a "commonsense view" of the Virginia statute discloses that it regulates certain insurance contracts, albeit indirectly through the structure of the PPO.

Furthermore, the Virginia statute passes muster under the three criteria that *Metropolitan Life*, 471 U.S. at 743, derived from *Pireno*. As *Pireno* notes: "None of these criteria is necessarily determinative in itself. . . ." 485 U.S. at 129. The Virginia statute satisfies the first criterion, "transferring or spreading the policyholder's risk." There are several components to the "policyholder's risk." They include the types of illness and injury that the insurance

contract covers, provision for treatment, and the cost of treatment. The Virginia statute affects the type and cost of treatment available to an insured. If a PPO unreasonably restricts the providers of treatment, even though they meet the insurer's standards, it denies an insured the choice of doctor or hospital that may best suit the insured's needs, unless the insured is willing and able to pay all or part of the cost of the doctor or hospital that is not preferred by the insurer. This is a restriction of the insured's benefits. By its prohibition against unreasonable restriction of providers, the Virginia statute spreads the cost component of the policyholder's risk among all the insureds, instead of requiring the policyholder to shoulder all or part of this cost when seeking care or treatment from an excluded doctor or hospital of his or her choice.

The Virginia statute satisfies the second criterion because it is "an integral part of the policy relationship between the insurer and the insured." *Metropolitan Life,* 471 U.S. at 743. We repeat, treatment and cost are important components of health insurance. Regulations governing these components, such as the Virginia statute, are integral parts of the relationship between insurer and insured. In this respect mandatory-provider regulations are conceptually similar to the mandatory-benefit law that *Metropolitan Life* held was a law regulating insurance and consequently not preempted by ERISA. 471 U.S. at 758. Moreover, in dicta, speaking of state regulation of the substantive terms of group health insurance contracts, the Court recognized that mandatory-provider statutes were among these terms in many states. *See Metropolitan Life,* 471 U.S. at 729 and n.9.

The Virginia statute also satisfies the third criterion. It is expressly "limited to entities within the insurance industry." *Metropolitan Life,* 471 U.S. at 743. ERISA's deemer clause, 29 U.S.C. § 1144(b)(2)(B), precludes employer self-funded employee benefits plans from being brought within the scope of Va. Code § 38.2-3407. The district court

observed that this difference in the regulation of employer-funded PPOs and insurer PPOs creates an anomalous situation. 800 F. Supp. at 336. But this anomaly does not counsel preemption. The Supreme Court referred to a similar situation in *Metropolitan Life*:

> We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the "deemer clause," a distinction Congress is aware of and one it has chosen not to alter.

471 U.S. at 747.

Though the Virginia statute regulates the relationship between the insurer and insured through the formation of the insurer's PPO, it is nonetheless a law regulating the business of insurance. The Supreme Court held in *SEC v. National Securities*, 393 U.S. at 460, and reiterated in *Metropolitan Life*, 471 U.S. at 744, that statutes regulating the relationship between insurer and insured "directly or indirectly are laws regulating the business of insurance."

Aetna relies primarily on *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), for the proposition that Va. Code § 38.2-3407 does not regulate the business of insurance within the meaning of the McCarran-Ferguson Act. *Royal Drug* concerned an antitrust challenge by several pharmacists to an insurance company's program requiring any pharmacy which desired to serve the company's policyholders to sell them prescription drugs for $2 and to seek reimbursement from the insurer for only the cost of acquiring the drugs. The Court held that these agreements were "merely arrangements for the purchase of goods and services" by the insurance company. 440 U.S. at 214. Consequently, it ruled that the program was not the business of insurance within the meaning of the McCarran-Ferguson Act and that it was not exempted from

antitrust laws. 440 U.S. at 214. To the same effect is *General Motors Corp. v. Caldwell*, 647 F. Supp. 585 (N.D. Ga. 1986), which relied on *Royal Drug* to preempt a statute dealing with a prescription drug program.

Aetna analogizes the Virginia statute to the drug purchase program described n *Royal Drug*. It characterizes the PPO regulation as merely facilitating the exchange of goods and services and thus not transferring or spreading risks. It emphasizes the fact that the regulation affects only the relationship between insurers and providers, not between insurers and insureds.

The practice at issue in *Royal Drug*, unlike Aetna's PPO, did not restrict the availability of benefits to insureds because any pharmacy which agreed to the insurance company's terms was allowed to participate. Aetna's characterization of the Virginia statute misconceives the relationship which the Virginia statute affects. As previously explained, although facially the statute only directly affects providers, it indirectly affects the insured's choice of provider and the consequent cost to the insured if he or she deems an excluded provider to be better qualified for treatment of a specific illness or accident. In this way it affects the risk that an insured must bear.

Aetna's claim that its PPO is simply a commercial transaction that reduces the cost of insurance overlooks the decision of the Virginia General Assembly to give priority to an insured's freedom to choose doctors and hospitals over the possibility of reduced insurance premiums. This legislative decision to favor an insured's choice of providers does not compel preemption. The wisdom of this decision is a concern of the legislature, not the judiciary.

Although the Court cited *Royal Drug* in *Metropolitan Life*, 471 U.S. at 743, it did not consider the outcome of *Royal Drug* to be precedent applicable to a statute prescribing mandatory benefits in health insurance contracts. Following the rationale of *Metropolitan Life*, we believe

that *Royal Drug* is not precedent applicable to the Virginia statute pertaining to mandatory providers in insurers' PPOs.

Other courts support our conclusion that because the Virginia statute regulates the business of insurance, ERISA does not preempt it. In *Blue Cross and Blue Shield v. St. Mary's Hospital*, ___ Va. ___ , 426 S.E.2d 117 (1993), the Supreme Court of Virginia relied on *Metropolitan Life*, 471 U.S. 724, to hold that a statute regulating non-stock insurance company PPOs regulated the business of insurance and thus escaped preemption by ERISA. In that case the issues were the same as those before us. A hospital excluded from a PPO sought redress. The Virginia Supreme Court noted the district court's opinion in *Stuart Circle*, which we are reviewing, and declined to follow it.

Reaching the same conclusion with respect to statutes mandating specialized providers are *Blue Cross and Blue Shield v. Bell*, 798 F.2d 1331, 1334-36 (10th Cir. 1986), and *Blue Cross Hospital Service v. Frappier*, 698 S.W.2d 326 (Mo. 1985).

The district court's judgment is vacated, and the case is remanded for further proceedings. The Hospital shall recover its costs.

VACATED AND REMANDED

APPENDIX C

IN THE
UNITED STATES DISTRICT COURT FOR THE
EASTERN DISTRICT OF VIRGINIA
Richmond Division

File No. 91-736

STUART CIRCLE HOSPITAL CORP.,
Plaintiff,

v.

AETNA HEALTH MANAGEMENT, *et al*,
Defendants.

FILED
JULY 22, 1992

MEMORANDUM OPINION

This matter is before the Court on the Defendant's Motion for Summary Judgment pursuant to Fed. R. Civ. P. 56. For the reasons stated below, the Defendant's motion is granted and the case is hereby dismissed with prejudice.

BACKGROUND

Stuart Circle Hospital Corporation ("Stuart Circle") seeks a judgment against the Defendants Aetna Life Insurance Co. and Aetna Health Management (collectively "Aetna") declaring that Aetna's actions in implementing and operating a preferred provider organization (the "Aetna PPO") are in violation of Va. Code § 38.2-3407 (the "PPO Statute") and enjoining further violations or operations until the Aetna PPO) is established in compliance with the PPO Statute.

Defendant Aetna variously administers and insures employee benefit plans in Virginia. Among the various products that Aetna offers its employee benefit plan customers in the Richmond area is a Preferred Provider Program, the main feature of which is the Aetna PPO. Aetna offers the Preferred Provider Program only to employee benefit plans.

The Aetna PPO in the Richmond area was originally established by Aetna in 1987, and is now managed by Aetna Health Management ("AHM"). AHM maintains the Aetna PPO through contracts with selected health care providers who agree (1) to provide services at discounts from their normal fees to individuals covered under employee benefit plans administered or insured by Aetna; and (2) to comply with the utilization review requirements of the employee benefit plans. In return, these providers expect an increase in patient volume because the employee benefit plans are designed to provide financial incentives for plan participants to select the preferred provider. AHM currently has preferred provider contracts with six Richmond area hospitals: Retreat, Richmond Memorial, St. Mary's, Henrico Doctors', Chippenham, and Johnston-Willis.

Currently, over 120 Richmond area employee benefit plans utilize Aetna's Preferred Provider Program. Some of these plans are self-insured, in which case Aetna acts as administrator of the employee benefit plan. In other cases, Aetna acts as both insurer and administrator of the employee benefit plan. However, the offers and negotiations between Aetna and the hospitals selected for the PPO did not involve any employee benefit plan, employer, or sponsor of an employee benefit plan. Rather, Aetna and the hospitals were the sole contracting parties in the process.

Stuart Circle claims that is was unreasonably excluded from the Aetna PPO, not because it could not meet Aet-

na's "terms and conditions," but because it was not a member of Aetna's HMO in Richmond. Stuart Circle demands that Aetna comply with the requirements of Virginia law governing the establishment of a PPO by an insurer.

Prior to determining the merits of the case, the Court required the parties to brief the issue of whether Plaintiff's claim may be preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et. seq.*. *See HCA Health Services v. Metropolitan Life Ins. Co.*, No. 91-2606 (4th Cir. Feb. 24, 1992) (slip op. at 8 n.1) ("The District Court erred in interpreting the Virginia statute before deciding if it was preempted by ERISA.").

ISSUE

This dispute involves the application and interpretation of Va. Code Ann. § 38.2-3407(B). The question presented is whether this provision is preempted by ERISA. To resolve this question, the Court must determine (1) whether § 38.2-3407(B) "relates to" employee benefit plans and thus comes under the purview of ERISA and (2) whether Virginia's PPO statute regulates the "business of insurance" as this term has been defined under the McCarran-Ferguson Act and thus comes within ERISA's "savings clause."

DISCUSSION OF AUTHORITY

The Plaintiff argues that Va. Code § 38.2-3407(B) does not "relate to" an employee benefit plan, and even if it did, it regulates insurance and, therefore, is saved from preemption by ERISA. The Defendant argues the very opposite—that the Virginia statute is preempted by ERISA but does not regulate the "business of insurance."

I. THE PPO STATUTE

The PPO Statute, Section 38.2-3407, provides as follows:

A. One or more insurers may offer or administer a health benefit program under which the insurer or insurers may offer preferred provider policies or contracts that limit the numbers and types of providers of health care services eligible for payment as preferred providers.

B. Any insurer shall establish terms and conditions that shall be met by a hospital, physician or type of provider listed in § 38.2-3408 in order to qualify for payment as a preferred provider under the policies or contracts. These terms and conditions shall not discriminate unreasonably against or among such health care providers. No hospital, physician or type of provider listed in § 38.2-3408 willing to meet the terms and conditions offered to it or him shall be excluded. Neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with providers based on market conditions or price differences among providers in different geographical areas, shall be deemed unreasonable discrimination. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.

II. PREEMPTION UNDER ERISA

An employee welfare plan is defined under ERISA as a plan which provides to employees "medical, surgicial, or hospital care or benefits, or benefits in the event of sickness, accident, disability [or] death," whether these benefits are provided "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1). Plans may self-insure or they may purchase insurance for their participants. Plans that purchase insurance—so-called "insured plans"— are directly affected by state laws that regulate the insurance industry.

ERISA imposes a variety of substantive requirements relating to participation, funding, and vesting upon welfare

plans, but does not regulate the substantive content of such plans. Thus, ERISA contains almost no federal regulation of the terms of benefit plans. It does, however, contain a broad preemption provision:

> Except as provided in subsection (b) of this section (the savings clause), the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.

ERISA § 514(a), 29 U.S.C. § 1144(a). Thus, any state law that "relate[s] to" an "employee benefit plan" is preempted,[1] unless it fits within one of the enumerated categories of permissible state regulation.

The United States Supreme Court has interpreted ERISA § 514(a) quite broadly. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). It has repeatedly recognized that the words "relate to . . . express a broad preemptive purpose." *Morales v. Trans World Airlines*, No. 90-1604 (U.S. June 1, 1992) (Slip op. at 7.).

A state law law "relate[s] to" an employee benefit plan "if it has a connection with or reference to such a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983) (holding that the New York Human Rights Law prohibiting employers from structuring employee benefit plans in a manner which discriminates on the basis of pregnancy relates to employee benefit plans and is, therefore, preempted by ERISA). Preemption is, moreover, not limited to "state laws specifically designed to affect employee benefit plans," nor is it limited to state laws that relate to subject matters addressed by ERISA. *Id.* at 98-99.[2] Even laws that have

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[1] "The Supremacy Clause of Article VI of the Constitution provides Congress with the power to pre-empt state law." *Louisiana Pub. Serv. Comm'n v. FCC*, 476 U.S. 355, 368 (1986).

[2] Of course, § 514(a) preempts state laws only insofar as they relate to plans covered by ERISA.

only indirect effects on private employee benefit plans are preempted if they "relate" to such a plan. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981).

Examination of Virginia Code § 38.2-3407 in light of these governing principles compels the conclusion that it is a law that "relate[s] to" employee benefit plans. By contrast, in arguing that the PPO Statute does not relate to employee benefit plans, the Plaintiff stresses that the provision "does not directly regulate the content of an employee benefit plan," and that "[t]he existence of an employee benefit plan is not central to or determinative with respect to the application" of the PPO Statute. (Pl. Mem. at 10.) Plaintiff then tries to minimize the statute's effect on employee benefit plans by describing the effect as "incidental" or "derivative." (Pl. Mem. at 5, 10, 11, 15, and 17) These points are not well taken.

Plaintiff's narrow reading of section 514(a) of ERISA ignores controlling precedent and is at odds with the purpose behind ERISA preemption. The Supreme Court specifically rejected an interpretation of "relate[s] to" that would have limited section 514(a) to "state laws specifically designed to affect employee benefit plans," *Shaw*, 463 U.S. at 98, and has held that even indirect state action bearing on pensions may encroach upon the area of exclusive federal concern. *Alessi*, 451 U.S. at 525. So long as a state law has a "connection with or reference to" an employee benefit plan, then the law relates to the plan, and it is of no consequence whether the effect on the plan is direct or indirect.[3]

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[3] The Court rejects the Plaintiff's contention that the Second Circuit's opinion in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985), requires a conclusion that the PPO Statute does not relate to employee benefit plans. In *Rebaldo*, the Court found that ERISA did not preempt a New York statute setting certain prices for certain hospital services for all purchasers of such services. The court concluded that the New York statute, which effectively prevented em-

Virginia's PPO Statute does have a clear connection to and effect on employee benefit plans. First, on its face, the statute states that an insurer may offer or administer a "health benefit program." This language appears to clearly contemplate employee benefit plans. Moreover, the chapter of the Virginia Code that includes section 38.2-3407 applies to *group* accident and sickness policies. *See* Va. Code §§ 38.2-3400(A), 38.2-109, and 38.2-3401. ERISA plans are, of course, group plans. *See* 29 U.S.C. § 1002(a).

Secondly, even though the PPO Statute does not directly regulate employee benefit plans, the statute affects those plans in such a manner as to fit within ERISA's preemptive reach. Section 38.2-3407 goes to the sum and substance of employee benefit plans: the delivery of promised benefits. *See General Motors Corp. v. Caldwell*, 647 F.Supp. 585, 587 (N.D. Ga. 1986) (statute regulating establishment of participating pharmacy agreements "strikes at the heart of a feature of employee benefit plans"). The reason why Stuart Circle wants to be included in Aetna's PPO is pre-

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ployee benefit plans from negotiating a reduced rate with hospitals, did not "relate to" employee benefit plans simply because it increased the plan's cost of doing business and because it increased the plan's cost of doing business and because it did "not affect the structure, adminstration or the type of benefits provided by an ERISA plan." *Id.* at 139.

However, unlike the New York statute in *Rebaldo*, whose sole relation to employee benefit plans was to increase the cost of doing business, the PPO Statute before the Court today does not simply increase the cost of doing business for employee benefit plan administrators. Virginia's PPO Statute would also affect the structure, administration, and the type of benefits provided by the plans. Moreover, *Rebaldo* pre-dates the Supreme Court's decision in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), in which the Court reiterated that even indirect impact on an employee benefit plan brings a state statute within the scope of ERISA preemption. And in fact, the Second Circuit itself has questioned the continuing vitality of *Rebaldo*. *See Smith v. Dunham-Bush, Inc.*, 959 F.2d 6, 9 n.3. (2d Cir. 1992).

cisely so it can gain entree into the lucrative business of supplying health care to employee benefit plans. Preferred provider arrangements, the target of the statute, are creatures of employee benefit plans. They are the principal means by which employee benefit plans deliver their promised medical benefits; as such, regulation of the structure of the PPO network necessarily affects the benefit plans and thus "relate[s] to" them.

By regulating the makeup of the PPO networks, the PPO Statute constrains how health benefits may be structured under an employee benefit plan and interferes with the discretion of the plan sponsor. Under the PPO Statute, an employee benefit plan which is insured or which chooses an insurer to administer the plan will have to include providers as preferred providers who would not otherwise be included. Thus, the statute prohibits effective limitation of the hospital provider network, and a critical cost containment feature of the employee benefit plans subscribing to Aetna's Preferred Provider Program is greatly diminished.[4]

The administration of the employee benefit plans is similarly affected. Whether a provider is "preferred" will affect the formula for benefit payments by employee benefit plans with respect to services rendered by that provider to plan participants. Through its contract with the Aetna PPO, the provider becomes directly "connected with" employee benefit plans administered or insured by Aetna. That a provider is "preferred" changes both the manner and amount of benefits paid by the employee benefit plan.

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[4] As this Court found in *HCA Health Services v. Metropolitan Life Ins. Co.*, "[t]he exclusion of some providers is a necessary prerequisite of a limited provider network. It is by limiting the number and types of providers included in a PPO that an insurer is able to implement cost reductions in services for health beneficiaries." C.A.90-285-R, slip op. at 3 (E.D. Va. Dec. 7, 1990).

The connection or effect that the PPO Statute has on employee benefit plans can be easily illustrated. Imagine Employee Benefit Plan X organizes a PPO network with four Richmond area health care providers. Not included in this list, for reasons peculiar to Plan X, is Stuart Circle Hospital. Plan X secures a 15% discount on all services for its beneficiaries. This discount is offered because the included hospitals expect that the beneficiaries of Plan X will have a great incentive to choose one of the network hospitals for their health care needs. Plan X's participants may go to another provider, but they will have to pay the difference in costs out of their own pockets. To administer this PPO, Employee Benefit Plan X hires Aetna, an insurance company. Under the mandate of Va. Code § 38.2-3407, if a district court has to order that Stuart Circle Hospital and other comparable health care providers must be included in the limited network, then clearly Plan X's benefit scheme will be effected. For instance, the original providers may determine to provide only 10% discounts or may impose other conditions. The end result is that the system carefully constructed by Plan X will be changed. For this reason, Virginia's PPO Statute, in both purpose and effect, "relate[s] to" employee benefit plans.

Indeed, a number of courts have recognized that state statutes regulating preferred provider arrangements necessarily relate to employee benefit plans. For instance, in *General Motors Corp. v. Cladwell*, 647 F.Supp. 585 (N.D. Ga. 1986), the Georgia statute at issue, like the Virginia statute here, required that all providers (pharmacies) willing to meet the terms of inclusion be entitled to become participating pharmacies. Ga. Code Ann. § 26-4-144(a). The court in *Caldwell* concluded that the Georgia law "clearly has an indirect but substantial relation to [employee benefit plans]" because it "regulates the discount features currently provided to plan beneficiaries" and creates an administrative scheme with which plan administrators have to comply. *Caldwell*, 647 F. Supp. at 587. The court noted

that "although the Act is not specifically denominated as a statute regulating employee benefit plans, it clearly targets them." *Id.; see also Blue Cross & Blue Shield v. Peacock's Apothecary, Inc.*, 567 F. Supp. 1258, 1276 (N.D. Ala. 1983) (holding in a similar case that "[a]lthough the Act directly regulates the agreements and relationships *between insurers and pharmacies*, it effectively regulates what employers and employees can and cannot include in employee benefit plans." (emphasis added)). The same can be said about Virginia's PPO Statute.

Adnan Varol, M.D., P.C. v. Blue Cross & Blue Shield, 708 F. Supp. 826 (E.D. Mich. 1989), is also instructive. There, providers of mental health care services brought suit against Blue Cross alleging that a program offered by General Motors to certain employees, which required preauthorization of mental health care services, violated certain state laws. The participating mental health care providers had contracted with Blue Cross, as the administrator of the General Motors plan, to render services to persons covered under the program in accordance with the program's managed care requirements, and to accept reimbursement for services rendered in accordance with the program's fee schedules.

The *Adnan Varol* Court held that the state law claims were preempted by ERISA because they went directly to the essence of the employee benefit plan—the preauthorization and managed care requirements—even though the contracts at issue were between Blue Cross and the providers. "[T]he provider contracts between plaintiffs and [Blue Cross] are merely the means for carrying out the benefit plan agreed to between GM and the U.A.W." *Id.* at 832. Similarly, in this case, Stuart Circle seeks to become a party to a preferred provider contract offered by Aetna. However, as the *Adnan Varol* Court notes, these contracts are merely the means for carrying out the employee benefit plans that utilize the Aetna PPO.

In short, the PPO Statute, Va. Code § 38.2-3407, "relate[s] to" employee benefit plans and is preempted under ERISA § 514(a) unless it is saved from preemption by one of the exceptions listed in ERISA § 514(b), 29 U.S.C. § 1144(b).

III. THE SAVINGS CLAUSE AND THE "BUSINESS OF INSURANCE"

State laws regulating insurance are "saved" from preemption by ERISA § 514(b) (2) (A) which provides:

> Except as provided in subparagraph (B) (the deemer clause), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

29 U.S.C. § 1144(b) (2) (A).

Whether a state law "regulates insurance" for purposes of ERISA is analyzed in accordance with the principles that have been developed under the McCarran-Ferguson Act.[5] The McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15, provides in part:

> No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any state for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance.

In *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982), the Supreme Court identified three factors for determining whether a practice is the "business of insurance" for purposes of the McCarran-Ferguson Act:

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[5] In *Metropolitan Life*, the Supreme Court recognized that the ERISA savings clause and the McCarran-Ferguson Act "serve the same federal policy and utilize similar language to define what is left to the States." 471 U.S. at 744 n.21.

> [*F*]*irst*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.

The Plaintiffs maintain that the PPO Statute at issue does not regulate the "business of insurance" under the three factor test of *Pireno*. First, the Plaintiff argues that the application of § 38.2-3407 operates to spread risk because if affects the type of coverage that must be provided pursuant to a preferred provider program established by an insurer. The prohibition against unreasonable discrimination in the terms and conditions governing provider participation is closely related to the scope of coverage mandated and the availability of services. As such, the Virginia statute regulates who can provide the covered services and how the health care provider is selected. The risk affected, therefore, is the cost of health care to be borne by the insurer or the beneficiary of the insurance program. Aetna offers the PPO in connection with its insurance products. The Plaintiff claims that the nexus between Aetna's insurance products and its PPO is sufficient to link the PPO to Aetna's insurance with respect to the transfer of risk.

The Plaintiff relies on the case of *Blue Cross and Blue Shield v. Bell*, 798 F.2d 1331 (10th Cir. 1986), in which the court ruled that Kansas statutes imposing mandated benefits and mandated provider requirements on health insurance policies were not preempted by ERISA because of the insurance savings clause. With respect to the first element of the McCarran-Ferguson test, the court stated:

> Insurance is an arrangement for transferring and distributing risk . . . . [T]he insured's right to choose the type of practitioner to fulfill the agreed upon coverage must figure into, and play a part in, the 'spreading

> and underwriting of a policyholder's risk.' (Citations omitted.) . . . Implicit in the coverage of [health] care is the insured's choice of a deliverer of the care. The choice of a provider does not add to the insured's coverage but is of the essence of that coverage bargained for as the transferred risk. Thus, the mandated provider statutes at issue satisfy the first criterion of the 'business of insurance.'

Bell, 798 F.2d at 1335.

Secondly, the Plaintiff argues that the PPO statute affects the policy relationship between the insurer and the insured. The statute affects the establishment of the service delivery mechanism, the types of providers that must be included, and preserves access to nonpreferred providers. All this affects the nature of the services available, who can provide those services, and who must be paid for those services. The Plaintiff argues that each of these factors is intimately related to the policy relationship.

Again, the Plaintiff relies on *Bell* with respect to the second element of the test:

> The second criterion is readily met. The selection of a particular provider is as integral to the bargained-for coverage as the coverage itself. The freedom to choose a treating physician is inextricable from the nature of the coverage provided. Because the policy alone has defined the limits of coverage, the insured's choice of a provider resides with the contractual relationship between the insurer and the insured. (Citation omitted.)

Id. at 1335.

Lastly, the Plaintiff argues that the ERISA savings clause applies because the PPO Statute is imposed solely on insurers. Section 38.2-3407 is a portion of Virginia's Insurance Code and its provisions apply solely to "insur-

ers" as defined in section 38.2-100. None of Plaintiff's arguments are persuasive.

As the Defendant correctly argues, the PPO statute in question does not regulate the "business of insurance," but, instead regulates the "business of insurance companies." While the former is saved from ERISA preemption, the latter is not. Applying the *Pireno* test, first, the agreements entered into between Aetna and various health care providers do not involve the spreading of risk. Unlike Stuart Circle, Aetna argues that its PPO is, in actuality, a cost saving arrangement, not a risk transferring mechanism, even if the cost-savings translate into lower premiums for the insured. *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 216 (1979).

For example, in *Royal Drug*, a Texas insurance company offered policies entitling insured persons to purchase prescription drugs for $2 each from any pharmacy participating in a "Pharmacy Agreement" with Blue Shield; policyholders could also purchase prescription drugs from nonparticipating pharmacies but would have to pay the full price and seek reimbursement from Blue Shield for a portion of the price. Any Texas pharmacy could participate, although the pharmacy was required by the plan to sell prescription drugs to Blue Shield's policyholders for $2 each, and were only remebursed for the costs of acquiring the drugs.

In analyzing these pharmacy agreements to determine if they qualified as the "business of insurance," the Supreme Court first noted that the agreements did not have the effect of transferring or spreading a policyholder's risk because they were "merely arrangements for the purchase of goods and services by Blue Shield." *Id.* at 214. The agreements served "only to minimize the costs Blue Shield incurs in fulfilling its underwriting obligations, *id.* at 213, and while "[s]uch cost-savings arrangements may well be sound business practice, and may well inure

ultimately to the benefit of policyholders in the form of lower premiums, . . . they are not the 'business of insurance.' " *Id.* at 214.

The arrangements between Aetna and the hospitals and physicians that participate in the Aetna PPO are similarly "for the purchase of goods and services," not involving the business of insurance.[6] Aetna contracts with various hospitals and physicians to provide health care to Aetna's customers, who may or may not be insured by Aetna.[7] Any transfer of risk occurs when (and if) Aetna insures a benefit plan, not when it minimizes its cost of fulfilling its contractual obligations. Thus, the arrangements are "legally indistinguishable from countless other business arrangements that may be made by insurance companies to keep their costs low and thereby also keep low the level of premiums charged to their policyholders." *Id.* at 215.

Secondly, the practice is not an integral part of the relationship between the insurer and the insured. Indeed, in many instances there is no insurer-insured relationship between Aetna and the employee benefit plan. As in *Royal Drug*, the agreements at issue are not between the insurer and the insured but, rather, between Aetna and hospitals/physicians. *See also Caldwell*, 647 F. Supp. at 589 ("As

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[6] *Jordan v. Group Health Ass'n*, 107 F.2d 239 (D.C. Cir. 1939), specifically relied on by the Supreme Court in *Royal Drug*, supports the Defendant's argument. In *Jordan*, the D.C. Circuit held that an arrangement between a corporation that contracted with physicians, hospitals, and others to provide medical services did not constitute the business of insurance. *Id.* at 247. Rather, the court concluded that the corporation's activities "constitute the quantity purchase of well-rounded, continuous medical service by its members." *Id.* Unlike the business of insurance which is principally concerned with risk, the corporation was "concerned principally with *getting services rendered* to its members and doing so at lower prices made possible by quantity purchasing and economics in operation." *Id.* (emphasis in original).

[7] Recall that Aetna sells access to its PPO as a thrid party administrator for self-funded plans.

the agreements are with parties outside the insurance industry, they do not meet the second criterion for identifying the 'business of insurance.' ") If the Virginia statute meant to regulate the business of insurance, its aim at the relationship between the insurer and medical providers is off target.

Finally, the practice being regulated is not limited to entities within the insurance industry. Various non-insurers maintain preferred provider programs in Virginia. PPO programs simply constitute a line of business in which Aetna, an insurance company, has entered. *See Caldwell*, 647 F. Supp. at 589 ("provision of prescription drugs through participating agreements is not a practice which is limited to the insurance industry"). Section 38.2-3407 does not regulate insurance contracts; it regulates a type of business entered into by insurance companies. This practice also "inevitably involves third parties wholly outside the insurance industry—namely, [hospitals and physicians]." *Pireno*, 458 U.S. at 132. In addition, the PPO Statute affects insurance companies even if they do not insure the employee benefit plan which has access to the PPO, but simply administer it. Thus, because the practice is one that frequently and inevitably involves entities outside the insurance industry, and sometimes does not even involve insurance at all, it does not meet the third criterion for identifying practices constitution the "business of insurance."

The Plaintiff's reliance on the Tenth Circuit's decision in *Bell* is misplaced. As discussed above, that case involved a Kansas statute that imposed mandated benefits and mandated provider requirements on health insurance policies. *Bell*, 798 F.2d at 1333. Statutes which specify what benefits *must be provided* are clearly distinguishable from the regulation of how those health care benefits are to be delivered, which is the focus of the PPO Statute. Thus, the practice at issue in *Bell* involved the regulation of activities far closer to the business of insurance than the

PPO arrangements entered into between Aetna and the various hospitals and physicians it contracts with to provide medical and health services to its customers.

In sum, the Court finds that the Virginia PPO Statute relates to employee benefit plans. First, this case is more analogous to *Royal Drug* and *Caldwell*, both of which involved participating pharmacy agreements, than it is to *Bell*. Second, taking a "common-sense view of the matter," *see Metropolitan Life*, 471 U.S. at 740, the PPO Statute seeks to regulate businesses that organize PPOs; the statute focuses on the relationship between insurers and those health benefit providers who participate in PPO networks. The statute does not involve the relationship between insurers and policyholders, such as the issuance, reliability, type, or interpretation of insurance contracts—the essence of the business of insurance. *See, e.g., SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969).

Moreover, under the PPO Statute, it is of no consequence whether or not the insurance company regulated is actually insuring any benefit plans at all. If section 38.2-3407 truly regulated the business of insurance, then the action of a non-insurer, say a third-party administrator, in offering a health benefit program containing a PPO should also constitute the business of insurance. This is, of course, not the case. *See FMC Corp. v. Holliday*, 111 S.Ct. 403, 409 (1990);[8] *Thompson v. Talguin Bldg. Products Co.*, 928

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[8] In *FMC Corp.*, the Supreme Court stated:

> We read the deemer clause to exempt self-funded ERISA plans from state laws that 'regulate insurance' within the meaning of the saving clause .... [S]elf-funded ERISA plans are exempt from state regulation insofar as that regulation 'relate[s] to' the plans. State laws directed toward the plans are pre-empted because the relate to an employee benefit plan but are not 'saved' because they do not regulate insurance. State laws that directly regulate insurance are 'saved' but do not reach self-funded employee benefit plans because the plans may not be deemed to be

F.2d 649, 652 (4th Cir. 1991). Thus, assuming that the PPO Statute does come within the purview of the savings clause, the statute would create the anomalous situation that insured plans or plans with PPOs administered by insurance companies would be regulated, while self-funded plans administered by other third-party administrators would not.

It certainly seems unreasonable to maintain that merely establishing a PPO network is engaging in the business of insurance. *See Jordan*, 107 F.2d at 247. And the fact that an insurance company establishes such a program does not convert a non-insurance relationship into one involving the business of insurance. *See SEC v. National Securities, Inc.*, 393 U.S. at 459-60 (noting that insurance companies do many things that are not the "business of insurance").[9]

The PPO statute is essentially one-sided. It does not transfer or distribute risk from insured to insurer or vice-versa. It simply tells an insurance company that if it desires to satisfy its health care obligations through the use of a preferred provider network, then it must set nondiscriminatory terms and conditions for all potential providers. In short, this statute does not regulate the "business

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> insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws.

111 S.Ct. at 409.

[9] In *SEC v. National Securities, Inc.*, 393 U.S. 453 (1969), the Court explained:

> The [McCarran-Ferguson Act] did not purport to make the states supreme in regulating all the activities of insurance *companies*; its language refers not to the persons or companies who are subject to state regulation, but to laws 'regulating the *business* of insurance.' Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the 'business of insurance' does the statute apply.

Id. at 459-60 (emphasis in original).

of insurance," and is thus not saved from preemption under ERISA.

CONCLUSION

Judgment will be entered for the Defendant. The Court is aware that, for good or bad, this decision means that Va. Code § 38.2-3407(B) is from this day forth unenforceable. However, in determining whether or not the PPO Statute is preempted by federal law, this effect is of no consequence. When federal preemption is invoked under the directive of the Supremacy Clause, it falls to this Court to examine the intent of Congress. By enacting ERISA, Congress explicitly mandated the preemption of state law as it relates to employee benefit plans, thereby displacing all state laws, even consistent ones, on the same subject. Thus, to the extent that this ruling creates a regulatory void in regards to preferred provider networks in Virginia, such a result is mandated by ERISA.

For the reasons stated above, the Defendant's Motion for Summary Judgment is granted.

Let the Clerk send a copy of this Memorandum Opinion and the accompany Order to all counsel of record.

7/22/92
DATE

/s/ Richard L. Williams
UNITED STATES DISTRICT JUDGE

APPENDIX D

STATUTORY PROVISIONS

Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144

(a) Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b)(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

McCarran-Ferguson Act, 15 U.S.C. § 1012

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

Virginia Code § 38.2-3407

A. One or more insurers may offer or administer a health benefit program under which the insurer or insurers may offer preferred provider policies or contracts that limit the numbers and types of providers of health care services eligible for payment as preferred providers.

B. Any such insurer shall establish terms and conditions that shall be met by a hospital, physician or type of provider listed in § 38.2-3408 in order to qualify for payment as a preferred provider under the policies or contracts. These terms and conditions shall not discriminate unreasonably against or among such health providers. No hospital, physician or type of provider listed in § 38.2-3408 willing to meet the terms and conditions offered to it or him shall be excluded. Neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with providers or based on market conditions, or price differences among providers in different geographical areas, shall be deemed unreasonable discrimination. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.

APPENDIX E

UNITED STATES OF AMERICA

FEDERAL TRADE COMMISSION

WASHINGTON, D.C. 20580

February 4, 1993

The Honorable Joseph P. Mazurek
Attorney General of the State of Montana
Justice Building
Helena, MT 59620

Dear Mr. Attorney General:

The staff of the Federal Trade Commission[1] is pleased to submit this response to your request for views on the possible competitive effects of maintaining in place the recently-enacted "any willing provider" law, which is set to sunset in July 1993. This law limits the ability of preferred provider organizations ("PPOs") to arrange for services through contracts with health care providers, by requiring a PPO to enter a contract with any provider willing to meet the terms the PPO sets. By preventing PPOs from limiting the panel of providers, the law discourages contracts with providers in which lower prices are offered in exchange for the assurance of higher volume. Although the law may be intended to assure consumers greater freedom to choose where they obtain services, it appears likely to have the unintended effect of denying consumers the advantages of cost-reducing arrangements and limiting their choices in the provision of health care services.

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[1] These comments are the views of the staff of the Federal Trade Commission, and do not necessarily represent the views of the Commission or any individual Commissioner.

I. Interest and experience of the Federal Trade Commission.

The Federal Trade Commission is empowered to prevent unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[2] Pursuant to this statutory mandate, the Commission encourages competition in the licensed professions, including the health care professions, to the maximum extent compatible with other state and federal goals. For several years, the Commission and its staff have investigated the competitive effects of restrictions on the business practices of hospitals and state-licensed health care professionals.

The Commission has observed that competition among third-party payors and health care providers can enhance the choice and availability of services for consumers and can reduce health care costs. In particular, the Commission has noted that the use by prepaid health care programs of limited panels of health care providers is an effective means of promoting competition among such providers.[3] The Commission has taken law enforcement action against anti-competitive efforts to suppress or eliminate health care programs, such as health maintenance organizations ("HMOs"), that use selective contracting with a limited

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[2] 15 U.S.C. § 41 *et seq.*

[3] Federal Trade Commission, Statement of Enforcement Policy With Respect to Physician Agreements to Control Medical Prepayment Plans, 46 Fed. Reg. 48982, 48984 (October 5, 1981); Statement of George W. Douglas, Commissioner, On Behalf of the Federal Trade Commission, Before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, United States House of Representatives, on H.R. 2956: The Preferred Provider Health Care Act of 1983 at 2-3 (October 24, 1983); *Health Care Management Associates*, 101 F.T.C. 1014, 1016 (1983) (advisory opinion). *See also* Bureau of Economics, Federal Trade Commission, Staff Report on the Health Maintenance Organization and Its Effect on Competition (1977).

panel of health care providers.[4] The staff of the Commission has submitted, on request, comments to federal and state government bodies about the effects of various regulatory schemes on the competitive operation of such arrangements.[5] Several of these comments have addressed "any willing provider" requirements for health care service contracts.[6]

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[4] *See, e.g., Medical Service Corp. of Spokane County*, 88 F.T.C. 906 (1976); *American Medical Association*, 94 F.T.C. 701 (1979), *aff'd as modified*, 638 F.2d. 443 (2d Cir. 1980), *aff'd by an equally divided court*, 455 U.S. 676 (1982); *Forbes Health System Medical Staff*, 94 F.T.C. 1042 (1979); *Medical Staff of Doctors' Hospital of Price George's County*, 110 F.T.C. 476 (1988); *Eugene M. Addison, M.D.*, 111 F.T.C. 339 (1988); *Medical Staff of Holy Cross Hospital*, No. C-3345 (consent order, Sept. 10, 1991); *Medical Staff of Broward General Medical Center*, No. C-3344 (consent order, Sept. 10, 1991); *see also American Society of Anesthesiologists*, 93 F.T.C. 101 (1979); *Sherman A. Hope, M.D.*, 98 F.T.C. 58 (1981).

[5] The staff of the Commission has commented on a prohibition of exclusive provider contracts between HMOs and physicians, noting that the prohibition could be expected to hamper pro-competitive and beneficial activities of HMOs and deny consumers the improved services that such competition would stimulate. *See, e.g.*, Letter from Bureau of Competition to David A. Gates, Commissioner of Insurance, State of Nevada (November 5, 1986).

[6] The staff submitted comments to the Massachusetts House of Representatives concerning legislation that would have required prepaid health care programs to contract with all pharmacy suppliers on the same terms (or offer subscribers the alternative of using any pharmacy they might choose), noting that the bill might reduce competition in both pharmaceutical services and prepaid health care programs, raise costs to consumers, and restrict consumers' freedom to choose health care programs. Letter from Bureau of Competition to Representative John C. Bartley (May 30, 1989, commenting on S.B. 526). The staff has submitted similar comments on similar legislation in Pennsylvania, New Hampshire, and California. Letter from Cleveland Regional Office to Senator H. Craig Lewis (June 29, 1990, commenting on S.B. 675); letter from Office of Consumer and Competition Advocacy to Paul J. Alfano (March 17, 1992, commenting on H.B. 470); letter from Office of Consumer and Competition Advocacy to The Honorable Patrick Johnston (June 26, 1992, commenting on S.B. 1986).

II. Description of Montana's "Any Willing Provider" Law.

Montana law permits "preferred provider" agreements between providers of health care services and health care insurers relating to the amounts charged and the payments to the providers.[7] The law apparently extends to agreements with all kinds of health care providers: hospitals, professional practitioners, pharmacies, and other providers of health care services.

The "any willing provider" requirement is a temporary provision, which was adopted in 1991. It requires that an insurer establish terms and conditions to be met by providers wishing to enter such agreements.[8] Any provider willing to meet those terms and conditions must be permitted to enter an agreement with the insurer that set them. This "any willing provider" requirement is set to terminate July 1, 1993. At that time, unless the requirement is extended by legislative action, the PPO law will explicitly deny that an insurer must negotiate or enter into agreements with any specific provider or class of providers.[9]

This comment will focus on how "any willing provider" requirements limit contracting between providers and third-party payors, and on how this limitation is likely to affect competition and consumers. The actual effects of Montana's law may be difficult to gauge, because it has been in effect only for a short time. The expectation that the requirement would end soon may have affected how provi-

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[7] Mont. Code Ann., Title 33, Ch. 22, Part 17 (1991).

[8] Mont. Code Ann. § 33-22-1704 (Temporary). These terms and conditions may not be discriminatory; however, the law permits differences among geographic regions or specialties, or differences among institutional providers, such as hospitals, that result from individual negotiation.

[9] Mont. Code Ann. § 33-22-1704(3).

ders and PPOs have dealt with each other. Thus, this comment is based on general principles, rather than Montana's particular experience.

III. Competitive importance of programs using limited-provider panels.

Over the last twenty years, financing and delivery programs that provide health care services through a limited panel of health care providers have proliferated, in response to increasing demand for ways to moderate the rising costs associated with traditional fee-for-service health care. These programs may provide services directly or arrange for others to provide them. The programs, which include HMOs and PPOs, typically involve contractual agreements between the payor and the participating health care providers. Many sources now offer limited-panel programs. Even commercial insurers, which in the past did not usually contract with providers, and Blue Cross or Blue Shield plans, which do not usually limit severely the number of providers who participate in their programs, now frequently also offer programs that do limit provider participation.

The popular success of programs that limit provider participation appears to be due largely to their perceived ability to help control costs. Economic studies have confirmed that, under health care arrangements that permit selective contracting, competition helps to moderate cost increases.[10]

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[10] Studies have examined the competitive effects of selective contracting, in particular California's experience with permitting hospitals to contract selectively. *See, e.g.*, J.C. Robinson and C.S. Phibbs, *An Evaluation of Medicaid Selective Contracting in California*, 8 J. Health Econ. 437 (1989). This study found that shifting from cost-reimbursement to permitting selective contracting moderated increases in hospital costs, particularly in more competitive local markets. This study concentrated on Medicaid experience; however, further studies based on private health insurance experiences confirm these findings. *See, e.g.*, D. Dranove et al., *Is hospital competition wasteful?* Rand J. Econ., Sum-

In addition, subscribers may benefit from broader product coverage and lower out-of-pocket payments that these cost savings may make possible. Competition among different kinds of third-party payor arrangements, including those that limit provider participation and those that do not, should ensure that cost savings are passed on to consumers. This principle would apply to all types of health care payment programs and health care providers.

Hospitals compete, ultimately, for the business of patients. A hospital may pursue the business of subscribers to PPO or HMO programs by seeking access to those subscribers on a preferential, or even an exclusive, basis. The hospital may perceive several advantages to such arrangements. A preferential or exclusive arrangement may assure the hospital of enough patients to make possible savings from economies of scale, for example, by spreading fixed costs over a larger volume of sales. At a minimum, it could facilitate business planning by making sales volumes more predictable. The arrangement may reduce transaction costs by reducing the number of third-party payors with whom the hospital deals, and may reduce marketing costs that would otherwise be incurred to generate the same business. To get access to the business and the advantages represented by these programs, hospitals compete with each other, offering lower prices and additional services, to get the payors' contracts.

Third-party payors find such arrangements attractive because they benefit from the providers' competition. Lower prices paid to providers could mean lower costs for a third-party payor. Not only might the amounts paid out for services be lower, but in addition administrative costs might be lower for a limited-panel program than for one requiring the payor to deal with, and make payments to,

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mer 1992; *see also* G. Melnick et al., The Effects of Market Structure and Bargaining Position on Hospital Prices, 11 J. of Health Economics 217 (Oct. 1992).

all or most of the providers doing business in a program's service area. A payor might find it easier to implement cost-control strategies, such as claims audits and utilization review, if the number of providers whose records must be reviewed is limited. And lower prices and additional services would help make the payor's programs more attractive in the prepaid health care market.

Consumers too may prefer limited-provider programs if the competition among providers leads to lower premiums, lower deductibles, or other advantages. Consumer preference for limited-panel programs would presumably mean that, in the consumers' view, these advantages would outweigh the disadvantages of limiting the choice of providers, such as reduced convenience or the occasional need to use a provider that is not part of the payor's contracted service. Limitations on choice are unlikely to be so severe that consumers' access to providers is inadequate. For just as competitive forces encourage providers to offer their best price and service to a payor in order to gain access to its subscribers, competition would also encourage payors to establish service arrangements that offer the level of accessibility that subscribers want. Consumers' ability to change programs or payors if they are dissatisfied with service availability would give payors an incentive to assure that the arrangements they make for delivery of covered health care services satisfy consumers.

IV. Effects of "any willing provider" requirements on limited-panel programs.

"Any willing provider" requirements may limit firms' ability to reduce the cost of delivering health care without providing any substantial public benefit. They may make it more difficult for third-party payors, including PPOs, to offer programs that have the cost savings and other advantages discussed above. Requiring that programs be open to all providers wishing to participate on the same terms may affect both cost and coverage. To the extent that

opening programs to all providers reduces the portion of subscribers' business that each contracting provider can expect to obtain, these providers may be less willing to enter agreements that contemplate lower prices or additional services. Moreover, since any provider would be entitled to contract on the same terms as other providers, there would be little incentive for providers to compete in developing attractive or innovative proposals. Because all other providers can "free ride" on a successful proposal formulation, innovative providers may be unwilling to bear the costs of developing a proposal. Thus "any willing provider" requirements may substantially reduce provider competition for this segment of their business.

Reduced competition among providers for PPO business can result in higher prices for services through PPOs. The higher prices for covered services, as well as the increased administrative costs associated with having to deal with many more providers, may raise the prices to subscribers for prepaid health care programs, or may force those programs to reduce benefits to avoid raising those prices.

Moreover, requiring programs to be open to more providers may not give the consumer benefits from greater choice. Subscribers may already choose other types of prepayment programs with fewer limits on the providers from which they may obtain covered services. Indeed, by reducing their competitiveness with other kinds of third-party payment programs, requiring PPOs to grant open participation may reduce the number, variety, and quality of prepayment programs available to consumers without providing any additional consumer benefit.

V. Conclusion.

In summary, we believe that "any willing provider" requirement may discourage competition among providers, in turn raising prices to consumers and unnecessarily restricting consumer choice in prepaid health care programs,

without providing any substantial public benefit. We hope these comments are of assistance.

Sincerely,

/s/ Michael O. Wise
Michael O. Wise
Acting Director

Supreme Court, U.S.
FILED
OCT 28 1993
OFFICE OF THE CLERK

No. 93-510

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,
Petitioners,

v.

STUART CIRCLE HOSPITAL CORPORATION,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

---

RESPONDENT'S BRIEF IN OPPOSITION

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QUESTION PRESENTED

The saving clause of Section 514(b)(2)(A) of ERISA operates "broadly to preserve the States' lawmaking power over" insurance by excepting from pre-emption any law of any State which regulates insurance. The question fairly presented by the Petition is:

Whether the Court should review a decision of the United States Court of Appeals for the Fourth Circuit holding that Virginia Code § 38.2-3407(B), which protects policyholders by regulating health insurers who restrict policy coverage by limiting the number or types of providers that policyholders may utilize and still get full reimbursement, is saved from ERISA pre-emption under the rationale of *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

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IN THE

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OCTOBER TERM, 1993

AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,
Petitioners,

v.

STUART CIRCLE HOSPITAL CORPORATION,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

---

Respondent's Brief In Opposition

Respondent Stuart Circle Hospital Corporation[1] ("Stuart Circle") respectfully requests that this Court deny the Petition for writ of certiorari of Aetna Life Insurance Company and Aetna Health Management (collectively, "Aetna"), which seeks review of the judgment and opinion of the United States Court of Appeals for the Fourth Circuit in this case.

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[1] In accordance with Rule 29.1, Respondent states that it is a subsidiary of Charter Medical Corporation.

OPINIONS AND ORDERS BELOW

The order, opinions, and judgments of the Fourth Circuit and the District Court are accurately identified and reproduced in the Appendix ("App.") to the Petition. Contrary to Aetna's statement, the opinion of the District Court is officially reported at 800 F. Supp. 328.

STATUTORY PROVISIONS INVOLVED

Aetna failed to reproduce in its Petition several provisions of Virginia Code § 38.2-3407 which are relevant to this case. The entire text of this section is reproduced in the Appendix hereto.

STATEMENT OF THE CASE

The Statement contained in the Petition filed by Aetna omits critical facts and obscures others; the Petition does not contain all "facts material to the consideration of the questions presented." Rule 14.1(g).

As part of its Insurance Code, Virginia has enacted a statute that protects consumers by regulating the terms of health insurance policies or contracts which take the form of preferred provider arrangements, commonly known as insurance PPOs. The statute is explicitly confined to insurers who sell a particular kind of insurance product. It regulates the offering of insurance policies "*that specify how services are to be covered* when rendered by preferred and nonpreferred classifications of providers." Virginia Code § 38.2-3407(A), (E) (emphasis added). If an insurer restricts the policy coverage by limiting the "numbers [or] types" of preferred providers that policyholders can utilize and still get full reimbursement, then the

statute comes into play.[2] It prohibits an insurer who issues such a policy from excluding any provider willing to meet the insurer's PPO terms, unless there is a reasonable basis for "discriminat[ing]" against them by withholding preferred provider status. *Id.*, § 38.2-3407(B).

Like other forms of commercial insurance products, the PPO approach has the potential for abuses that ultimately threaten consumer welfare.[3] A danger is that insurers anxious to cut costs will limit the number or types of preferred providers so severely as to interfere with the legitimate interests of policyholders and their families in having a reasonable and economical range of choice of hospitals and physicians. The Virginia legislature chose to safeguard these interests by enacting Code § 38.2-3407. The statute allows insurers to offer insurance policies with limited coverage but also assures policyholders of sufficient

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[2]Aetna wrongly implies that the Virginia statute regulates insurance companies which simply administer self-funded employee benefit plans, *i.e.*, plans that do not purchase insurance. (*See* Pet. at 4.) In fact, the only activity of insurers regulated by the statute is their performance of an insurance function. The Fourth Circuit removed any doubt that this is so, holding that "ERISA's deemer clause, 29 U.S.C. § 1144(b)(2)(B), precludes employer self-funded employee benefits plans from being brought within the scope of Va. Code § 38.2-3407." (App. 10a.) *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 746-47 (1985).

[3]The record shows that Aetna's PPO is the third, and most recent, development in its "triple option" insurance portfolio. Subscribers are offered the option of receiving health care benefits from an indemnity policy, a health maintenance organization (HMO), or a PPO. A danger in indemnity insurance is over-utilization of health care services, and a corresponding danger of HMOs is under-utilization. State insurance regulation exists to balance the competing interests of insurers and consumers in these and other matters.

choice of providers who perform the terms of the insurance contract.[4]

An insured's choice of providers is an integral part of the coverage furnished by a health insurance policy. As the Fourth Circuit emphasized in its opinion, treatment and cost are vital components of the insurer-policyholder relationship that centers around the insurance contract. App. 10a. Because the insurance policy alone defines the limits of coverage, the insured's choice of a provider resides within the contractual relationship between the insurer and insured. The Virginia statute imposes requirements upon insurers with the intent of affecting this relationship. By prohibiting insurers from undue restriction of insurance coverage, the Virginia statute gives priority to an insured's freedom to choose doctors and hospitals. App. 12a. If a PPO unreasonably restricts a patient's choice of a suitable provider of treatment, even though the favored providers may meet the insurer's standards, the policyholder is forced to obtain care from an unwanted provider or to pay an additional charge for utilizing a provider of his or her choice. In either case, such a restriction necessarily affects the quality and cost of

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[4]Aetna mischaracterizes the Virginia statute when it asserts that the law "mandates that no health care provider willing to meet the terms and conditions of such a PPO may be excluded" from the network. (Pet. at 4). The statute permits even willing providers to be excluded if the insurer's terms and conditions for inclusion in the PPO network do not "discriminate unreasonably against or among such health care providers." Va. Code § 38.2-3407(B). *See HCA Health Services of Va., Inc. v. Metropolitan Life Ins. Co.*, 752 F. Supp. 202, 207 (E.D. Va. 1990), *appeal dismissed*, 957 F.2d 120 (4th Cir. 1992).

the treatment benefits available to the policyholder under the insurance contract. App. 10a.[5]

Mindful of these matters, the Fourth Circuit conducted a *de novo* review of the District Court's grant of summary judgment in favor of Aetna, and unanimously reversed. Applying the two-step analysis that ERISA requires, the Fourth Circuit first considered whether the Virginia statute comes within the terms of ERISA's pre-emption clause. The court found that the Virginia statute applies to health benefit programs operated by insurers and "has at its core a provision relating to the *benefits* which an insured may receive from an insurer's PPO." App. 7a (emphasis added). The court concluded that Va. Code § 38.2-3407 "relates to" employee benefit plans, 29 U.S.C. § 1144(a), and was therefore pre-empted "unless ERISA's insurance savings clause applies." App. 7a.

In the part of its decision for which Aetna seeks review, the Fourth Circuit then considered whether the Virginia statute is saved from pre-emption by ERISA as a law "which regulates insurance."[6] In conducting

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[5]Aetna's suggestion (Pet. at 3, 5-6) that patients are indifferent to the matter of who provides them with their medical treatment benefits, or that policyholders' risks are unaffected by the arrangements their insurers make to perform the health insurance contract, is therefore unfounded and incorrect. *See* App. 9a-10a.

[6]29 U.S.C. § 1144(b)(2)(A). Although the pre-emption and insurance saving clauses of ERISA are to be analyzed separately, the Fourth Circuit's rationale for holding that the Virginia statute satisfies the pre-emption clause is both relevant to and logically consistent with its saving clause analysis. That is to say, if the statute relates to employee benefit plans by regulating the "benefits" available to insureds under insurance PPO contracts, as the Fourth Circuit held, then it follows that the statute regulates insurance and is saved from pre-emption, as the court also held. Aetna's Petition ignores the interplay of these two parts of the Fourth Circuit's decision.

that analysis, the Fourth Circuit viewed as controlling this Court's analysis and holding in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). The court applied the tests announced in *Metropolitan Life* (App. 8a-10a) and reasoned that the Virginia statute is "conceptually similar to the mandatory-benefit law that *Metropolitan Life* held was a law regulating insurance and consequently not pre-empted by ERISA." App. 10a. The Fourth Circuit expressly rejected Aetna's claim that the Virginia statute is analogous to the practice at issue in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). Following the rationale of *Metropolitan Life* and several other courts,[7] the Fourth Circuit held that *Royal Drug* is "not precedent applicable to the Virginia statute pertaining to mandatory providers in insurers' PPOs." App. 12a-13a.

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[7] *See Blue Cross and Blue Shield of Kansas City v. Bell*, 798 F.2d 1331 (10th Cir. 1986); *Blue Cross Hospital Serv. of Mo., Inc. v. Frappier*, 698 S.W.2d 326 (Mo. 1985) (in banc).

REASONS FOR DENYING THE WRIT

SUMMARY OF ARGUMENT

The Petition raises no issue that warrants review. No significant or unsettled question of federal law is presented, no conflict among the Circuits exists, and the decision of the Fourth Circuit is correct on the merits and is not contrary to ERISA or any of the several applicable decisions of this Court.

The Petition raises no important questions of federal law which have not already been settled by the Court. Rule 10.1(c). In *Metropolitan Life*, the Court announced the two-part test for determining the scope of ERISA's insurance saving clause, which the Fourth Circuit faithfully employed here and which petitioners would have this Court employ once again. The Court in *Metropolitan Life* held that state regulation regarding the substantive terms of insurance contracts, as here, falls "squarely within the saving clause" as laws which regulate insurance. Moreover, regardless of whether the Virginia statute is likened to the mandated-benefit law at issue in *Metropolitan Life*, as the Fourth Circuit held, or to a mandated-provider law, as Aetna suggests, *Metropolitan Life* also makes clear that both types of laws are subclasses of a matrix of state laws that regulate the content of insurance contracts, and hence the Virginia law is saved from ERISA preemption. All decisional authority of the federal and state courts on this point is to the same effect.

The Fourth Circuit has not "rendered a decision in conflict with the decision of another United States court of appeals on the same matter." Rule 10.1(a). Aetna in one breath suggests that the decision conflicts with the Third Circuit's antitrust decision in *Ticor Title Ins. Co. v. FTC*, 998 F.2d 1129 (3rd Cir. 1993), and then in another concedes that no "direct"

conflict with *Ticor* actually exists, nor is there a split of circuit authority "on the precise issue in this case." This concession is not surprising. The outcomes in this case and in *Ticor* were different because the facts at issue in each case were materially different. In this case, unlike *Ticor*, the statute regulates the contents of an insurance contract and is therefore saved from pre-emption under the rationale of *Metropolitan Life*. Moreover, during the past Term, in *United States Dep't of Treasury v. Fabe*, 113 S. Ct. 2202 (1993), this Court held that cases interpreting the scope of antitrust exemption contained in the "second clause" of section 2(b) of the McCarran-Ferguson Act, such as *Ticor*, do not control the issue in litigation here. *Ticor* itself recognizes the *Fabe* holding on this point.

Finally, the Fourth Circuit has not decided a federal question in a way that conflicts with applicable decisions of this Court. Rule 10.1(c). Sidestepping the Fourth Circuit's holding that *Metropolitan Life* controls the outcome of this case, Aetna argues that the decision below is contrary to this Court's earlier decision in *Royal Drug*, a non-ERISA case. The Fourth Circuit correctly pointed out, however, that unlike the drug reimbursement program at issue in *Royal Drug*, which affected *only* the relationship between insurers and providers, the Virginia statute affects the core relationship between insurers and insureds by regulating the coverage available to policyholders under the insurance contract. On this basis the Fourth Circuit refused to view *Royal Drug* as applicable precedent, consistent with *Metropolitan Life* and several other courts in parallel cases. Moreover, Aetna's argument fails to acknowledge that *Fabe* is explicit in holding that *Royal Drug* does not control cases, such as this one, where the issue concerns interpretation of the "first clause" of section 2(b) of the McCarran-Ferguson Act. The Fourth Circuit's decision, which reached the same result but for

different reasons, thus correctly applied and anticipated the applicable precedents of this Court.

At bottom, the Petition rests upon the novel argument that insurers such as Aetna, whose self-interested views about how best to promote the welfare of policyholders did not carry the day in the Virginia legislature, and who failed to convince the Fourth Circuit that ERISA nullifies this salutary form of state insurance regulation, ought now to have a hearing in this Court because this case presents important issues of public policy. But the Fourth Circuit's rejoinder is no less telling here than as before: "[The] legislative decision to favor an insured's choice of providers does not compel preemption. The wisdom of this decision *is a concern of the legislature, not the judiciary*." App. 12a (emphasis added).

NO SPECIAL AND IMPORTANT REASONS EXIST FOR REVIEW ON WRIT OF CERTIORARI

A. The Fundamental Issues of Federal Law Raised by the Petition Have Already Been Settled by this Court

ERISA's insurance saving clause, 29 U.S.C. § 1144(b)(2)(A), provides that "nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance...." This clause operates to except, or "save," state laws regulating insurance from pre-emption that would otherwise occur by application of the preceding provision of ERISA, 29 U.S.C. § 1144(a) (pre-empting state laws which "relate to" employee benefit plans). Aetna's Petition seeks review only of that portion of the Fourth Circuit's decision in which it held that the Virginia statute falls within the insurance saving clause.

This Court is no stranger to "the burgeoning volume of litigation involving ERISA preemption claims" in general,[8] and the insurance saving clause of ERISA in particular. It has comprehensively addressed the basic issues presented by Aetna's Petition in prior cases, and the principles declared by the Court in those cases squarely dictate the outcome of this case. The Court's precedents establish that ERISA's insurance saving clause broadly preserves the States' lawmaking power over insurance, even if the effect of such laws is *indirectly* to regulate employee benefit plans which purchase insurance; they articulate the legal standards for deciding whether a state law regulates insurance; and they hold that mandated-benefit and other similar laws which regulate the substantive content of insurance contracts are saved from ERISA pre-emption. Together, those precedents furnish all the guidance needed by the Fourth Circuit to decide this case correctly.

First of all, the basic principles for interpreting the scope of ERISA's insurance saving clause are firmly settled. The Court has established that the saving clause operates "broadly to preserve the States' lawmaking power over" insurance from ERISA pre-emption. *Metropolitan Life*, 471 U.S. at 740; *see id.* at 746 n.24 ("the saving clause is broad on its face and specific in its reference."). Moreover, the Court has instructed the courts to "presume that Congress did not intend to pre-empt areas of traditional state regulation" such as insurance. *Id.* at 740. These principles apply even if the effect of a state insurance law is indirectly to regulate employee benefit plans

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[8] *District of Columbia v. Greater Washington Bd. of Trade*, 113 S. Ct. 580, 586 & nn. 2-3 (1992) (Stevens, J. dissenting) (citing the Court's prior cases and noting that "[a] recent LEXIS search indicates that there are now over 2,800 judicial opinions addressing ERISA pre-emption.").

which purchase insurance. *Id.* at 747 (recognizing "a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not."); *see FMC Corp. v. Holliday*, 498 U.S. 52, 64 (1990) ("the saving clause retains the independent effect of protecting state insurance regulation of insurance contracts purchased by employee benefit plans."). The insurance saving clause, therefore, is to be read broadly in exactly the opposite direction of the pre-emption clause—to preserve state regulation of insurance purchased by employee benefit plans from federal pre-emption.[9]

Second, this Court has settled the legal standards governing whether a state law "regulates insurance" within the meaning of ERISA's insurance saving clause. In *Metropolitan Life*, the Court addressed the saving clause in the context of determining whether a state statute which mandated a minimum level of mental health benefits regulated insurance and was

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[9]Consequently, Aetna's extensive argumentation (Pet. at 8-15) that the Fourth Circuit's decision will have "profound adverse consequences" for employee benefit plans which purchase insurance, does not address the question presented by its Petition. If ERISA's insurance saving clause removes a law such as the Virginia statute from pre-emption, then it is irrelevant that the law regulates, for better or worse, insurers who issue insurance contracts purchased by employee benefit plans. In such a case, the wisdom of the regulation is exclusively the concern of the States. Indeed, the Court in *Metropolitan Life* explicitly rejected the line of argument with which Aetna leads off its Petition:

> We also are aware that appellants' construction of [ERISA] would eliminate some of the disuniformities currently facing national plans that enter into local markets to purchase insurance. Such disuniformities, however, are the inevitable result of the congressional decision to "save" local insurance regulation. Arguments as to the wisdom of these policy choices must be directed at Congress. (471 U.S. at 747.)

thus saved from ERISA pre-emption. The Court approached its task by employing a two-part analysis. First, the Court took a "common-sense" approach, finding that the statute at issue regulated insurance contracts and thus logically should be encompassed by the "which regulates insurance" language of the saving clause. 471 U.S. at 740-41. Second, the Court examined the case law which interpreted the phrase "business of insurance" with respect to the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq*. To illustrate that Massachusetts' mandated-benefit law was a regulation of the business of insurance and, therefore, not pre-empted by ERISA, the Court reiterated:

> Congress was concerned [in the McCarran-Ferguson Act] with the type of state regulation that centers around the contract of insurance.... The relationship between insurer and insured, the type of policy which could be issued, its reliability, its interpretation, and enforcement—these were the core of the "business of insurance." [T]he focus [of the statutory term] was on the relationship between the insurance company and the policyholder. *Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the "business of insurance."*

Metropolitan Life, 471 U.S. at 743-44 (*quoting SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969)) (emphasis added). *See also United States Dep't of Treasury v. Fabe*, 113 S. Ct. at 2210 ("The broad category of laws enacted 'for the purpose of regulating the business of insurance' consists of laws that possess the 'end, intention or aim' of adjusting, managing, or controlling the business of insurance.").

Finally, the Court in *Metropolitan Life* held that state mandated-benefit laws are "only one variety of a

matrix of state laws that regulate the substantive content of health-insurance policies to further state health policy." 471 U.S. at 729. The Court described other varieties of laws that fall within the matrix, and specifically identified mandated-provider laws as one of them.[10] It is no surprise, therefore, that after *Metropolitan Life* all of the courts presented with the question of whether a mandated health provider statute "regulates insurance" within the meaning of ERISA have agreed that it does. *See Blue Cross and Blue Shield of Kansas City v. Bell*, 798 F.2d at 1334-36; *Blue Cross Hospital Serv., Inc. v. Frappier*, 698 S.W.2d at 327 ("We see no viable distinction between the mandated-benefit provisions involved in *Metropolitan Life* and our mandated provider statutes.").[11]

The bottom line is that the Petition presents no important issue of federal law that has not already been settled by this Court's existing precedents.

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[10] *See id.* ("Others require insurers to offer or mandate that insurance policies include coverage for services rendered by a particular *type* of health-care provider.") (footnote omitted, emphasis added). *Compare* Va. Code § 38.2-3407(A) (authorizing health insurers to "offer preferred provider policies or contracts that limit the numbers and *types* of providers of health care services....") (emphasis added).

[11] Likewise, the Virginia Supreme Court viewed *Metropolitan Life* as controlling authority when it held that Va. Code § 38.2-4209, which regulates non-stock insurers in exactly the same way as the Virginia statute at issue here, regulates insurance within the meaning of ERISA's insurance saving clause. *Blue Cross and Blue Shield of Va. v. St. Mary's Hospital of Richmond*, 245 Va. 24, 33, 426 S.E.2d 117, 122 (1993).

B. The Fourth Circuit's Decision is in Harmony with the Applicable Decisions of this Court

The Fourth Circuit took care to conform its decision in this case to the decisions of the Court. The court first applied the *Metropolitan Life* test of "common sense" to the Virginia statute, which confirms the obvious proposition that the statute regulates the contractual relationship between the insurer and the insured and the type of policy which could be issued. App. 9a; *see Bell*, 798 F.2d at 1335 ("The selection of a particular provider is as integral to the bargained-for coverage as the coverage itself.").

Next, the Fourth Circuit considered whether the Virginia statute satisfies the *Pireno* criteria for finding the "business of insurance" under the McCarran-Ferguson Act. *See Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982). The Fourth Circuit found that statute has the effect of "'transferring or spreading the policyholder's risk'" because it affects both "the type and cost of treatment available to an insured." App. 9a-10a. The statute regulates the benefits available to a policyholder under the insurance contract by making it less likely that he or she will be forced to accept care from an unsuitable provider or pay an extra-premium penalty for choosing another provider. Either way, the statute "spreads the cost component of the policyholder's risk among all the insureds" who pay premiums. App. 10a. Aetna's argument that the statute affects only an insurer's costs, and not also the quality and price of an insured's benefits, is thus plainly incorrect, as the Fourth Circuit and other courts have ruled. *See Bell*, 798 F.2d at 1335 (state laws that protect "the insured's right to choose the type of practitioner to fulfill the agreed upon coverage must figure into, and

play a part in, 'spreading and underwriting of a policyholder's risk.'").[12]

In reaching its decision, the Fourth Circuit correctly reasoned that the Virginia statute, which "has at its core a provision relating to the *benefits* which an insured may receive from an insurer's PPO," is conceptually similar to the mandated-benefit law that *Metropolitan Life* held was saved from ERISA pre-emption. App. 7a (emphasis added), 10a. Aetna argues, as it did below, that "[t]his case involves a mandatory *provider* law fundamentally different from the mandatory benefit law at issue in *Metropolitan Life* . . . ." Pet. at 21 (emphasis in original). As the Fourth Circuit recognized, however, *Metropolitan Life* could not have been more clear in equating both types of laws as subclasses of an overall matrix of traditional state regulation of the content of insurance contracts that is saved from ERISA pre-emption. App. 10a; *see* 471 U.S. at 727-28. Aetna conveniently ignores the importance of this guidance in its Petition.

At the heart of Aetna's Petition is the claim that the Fourth Circuit's decision is contrary to this Court's decision in *Royal Drug*. This is wrong in two independent respects. First, Aetna overlooks crucial fact differences between *Royal Drug* and this case, which the Fourth Circuit correctly understood as

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[12]The Fourth Circuit also correctly decided that the Virginia statute satisfies the second and third of the *Pireno* criteria. The court found that insurers' practice of restricting the coverage of insurance contracts by limiting the number and types of providers who deliver health care benefits to insureds affects basic components of health insurance, treatment and cost. As such, Virginia's regulation of those components is "an integral part of the policy relationship between the insurer and the insured" and is limited to the "insurance industry." App. 10a. Aetna abandons any direct challenge to the Fourth Circuit's holding on these points.

depriving *Royal Drug* of any precedential value here.[13] Second, Aetna fails to appreciate that this Court's recent decision in *Fabe* holds that *Royal Drug* does not control cases, such as this one, where the issue is whether a state law "regulates the business of insurance."

The Fourth Circuit found that the Virginia statute is a benefit-regulation law similar to the statute in *Metropolitan Life* because it "has at its core a provision relating to the benefits which an insured may receive from an insurer's PPO." App. 7a. An insured's "treatment and costs are important components of health insurance"; these benefits are "integral parts of the relationship between insurer and insured." *Id.* at 10a. The Virginia statute, which regulates the practice of insurers of restricting these benefits, thus affects the heart of the relationship between insurers and insureds, not simply or only the relationship between insurers and providers. *Id.* at 12a. In contrast, "[t]he practice at issue in *Royal Drug*, unlike Aetna's PPO, did not restrict the availability of benefits" to policyholders. *Id.*; *see Royal Drug*, 440 U.S. at

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[13]Aetna also attempts to suggest that there is a conflict within the Fourth Circuit with respect to the meaning of *Royal Drug*. (Pet. at 24-26.) However, Rule 10.1(a) makes no reference to a conflict within a circuit; it speaks only to a conflict with another circuit. In any event, there is no conflict within the Fourth Circuit. The Circuit's 1980 antitrust decision cited by Aetna, *Virginia Academy of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981), is inapposite to the facts of this case and relied principally upon *Royal Drug*. Having correctly decided that *Royal Drug* has no precedential value in this case, the Fourth Circuit can hardly be faulted for disregarding Aetna's "copious citation" of *Virginia Academy*.

213-14.[14] Just as the Court in *Metropolitan Life* did not consider *Royal Drug* to be precedent applicable to a statute prescribing mandated-benefits in health insurance contracts, the Fourth Circuit correctly rejected Aetna's suggestion that *Royal Drug* is applicable to this case. *See* App. 12a-13a; *Bell*, 798 F.2d at 1335 ("Unlike *Royal Drug*, . . . the provider practice at issue in this case involves the very implementation of the terms of the policy."); *Frappier*, 698 S.W.2d at 327 (on remand for consideration in light of *Metropolitan Life*) (declining to follow *Royal Drug* because the state statutes at issue "clearly relate to the benefits available to insured persons under health insurance contracts.").

In addition, although it was unnecessary to its decision, the Fourth Circuit's refusal to follow *Royal Drug* nonetheless correctly anticipated this Court's

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[14]The issue in *Royal Drug* was whether the federal antitrust laws could be invoked by a group of drug stores who complained that an insurer had violated the Sherman Act by entering into agreements fixing a maximum price at which the insurer would reimburse stores who filled prescriptions for its policyholders for $2 apiece. *Id.* at 207-08. The Court's analysis in that case was driven by crucial facts that distinguish *Royal Drug* from this case, which Aetna overlooks in its Petition. In *Royal Drug* the Court emphasized that policyholders were "basically unconcerned" with the insurer's reimbursement arrangement with drug stores because it "merely" reduced the insurer's costs without also affecting policyholder-insurer relationship to any significant degree. *Id.* at 214 & n.11. That is, prescriptions would always be available to policyholders for $2 regardless of the details of reimbursement between the insurer and drug store. The benefit structure of the insurance policy and, therefore, the policyholder's risk, were not materially affected by the reimbursement arrangement. In marked contrast, the Fourth Circuit here found that insurers' practice of restricting policy coverage by limiting the number and types of eligible medical providers directly implicates "important" components of policyholder risk, treatment and cost, which are "integral parts of the relationship between insurer and insured." App. 10a.

decision in *Fabe*. ERISA's insurance saving clause excepts from pre-emption any state law which "regulates insurance." 29 U.S.C. § 1144(b)(2)(A). *Fabe* has clarified that whether a state law regulates insurance under this section of ERISA is to be determined by the same criteria used to determine whether a state law is saved from federal pre-emption by the *first* clause of section 2(b) of the McCarran-Ferguson Act. *See* 15 U.S.C. § 1012(b) ("No Act of Congress shall be construed to invalidate, impair or supersede any law enacted by any State for the purpose of regulating the business of insurance, ..."). In *Fabe*, this Court held that *Royal Drug* and other cases (such as *Ticor*) which interpret the scope of the antitrust exemption of the *second* clause of section 2(b) of the Act—where the word "regulate" does not appear—do not control interpretation of the statutory language at issue in *Fabe*, and thus in this case as well. The Court in *Fabe* reasoned that:

> Both *Royal Drug* and *Pireno*, moreover, involved the scope of the antitrust immunity located in the *second* clause of § 2(b). We deal here with the *first* clause, which is not so narrowly circumscribed. The language of § 2(b) is unambiguous: the first clause commits laws "enacted . . . for the purpose of regulating the business of insurance" to the States, while the second clause exempts only "the business of insurance" itself from the antitrust laws. To equate laws "enacted . . . for the purpose of regulating the business of insurance" with the "business of insurance" itself, as petitioner urges us to do, would be to read words out of the statute. This we refuse to do.

113 S. Ct. at 2209-10 (emphasis in original). On this basis the *Fabe* Court refused to follow *Royal Drug*.[15]

Fabe thus adds gloss to *Metropolitan Life*, where the Court first explained why cases interpreting the scope of the McCarran-Ferguson Act are relevant to interpretation of ERISA's saving clause: "The ERISA saving clause, with its *similarly worded* protection of 'any law of any State which regulates insurance,' appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States." *Metropolitan Life*, 471 U.S. at 744 n.21 (emphasis added). ERISA's insurance saving clause and the first clause of section 2(b) of McCarran-Ferguson contain the same language and both serve the same policy. Because, as *Fabe* recognized, the second clause of section 2(b) is worded differently and serves a different purpose, 113 S. Ct. at 2210, *Royal Drug* does not control this case. The Fourth Circuit's decision, therefore, cannot be in conflict with *Royal Drug*.

C. The Wisdom of the Public Policy Choice Made by the Virginia Statute is a Concern of the Legislature, not the Judiciary

In the final analysis, the Petition is far more a reflection of Aetna's disagreement over the wisdom of legislative policy inherent in the Virginia statute than a genuine claim that the Fourth Circuit's decision warrants exercise of supervisory intervention by this

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[15]The dissenting opinion in *Fabe* acknowledges the majority's holding that "cases such as *Royal Drug*... do not control cases in which the first clause of [section 2(b) of McCarran-Ferguson] is at issue." 113 S. Ct. at 2215 (Kennedy, J., dissenting). The Third Circuit in *Ticor* acknowledged the same point. 998 F.2d at 1136. The holding in *Fabe* thus defeats Aetna's suggestion of an inter-circuit conflict here.

Court. Argumentation is hardly needed, however, to demonstrate that the judiciary has no authority to abrogate a function reserved by Congress to state regulators. Mindful of this basic truth, the Fourth Circuit appropriately declined Aetna's invitation to second-guess the judgment of the Virginia General Assembly about how best to protect the welfare of its citizens:

> Aetna's claim that its PPO is simply a commercial transaction that reduces the cost of insurance overlooks the decision of the Virginia General Assembly to give priority to an insured's freedom to choose doctors and hospitals over the possibility of reduced insurance premiums. This legislative decision to favor an insured's choice of providers does not compel preemption. The wisdom of this decision is a concern of the legislature, not the judiciary. (App. 12a.)

If, as Aetna speculates (Pet. at 26), a direct split of authority among the circuits may never arise on the precise issue presented in this case, it will be because future courts are as prudent as the Fourth Circuit was in respecting the limits of judicial power. No sound reason exists why this Court would or should conclude any differently.[16]

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[16]Even if this Court were a proper forum for resolving public policy choices, which it obviously is not, there is further reason for the Court to decline to issue the writ. The Administration has asked Congress to decide whether to enact legislation expressly pre-empting States' "willing provider" laws in certain circumstances. *See Preliminary Draft of the President's Health Reform Proposal 76* (1993). Regardless of how Congress decides this complex matter, the issue of the legal status of state laws such as the Virginia statute may well be settled conclusively without further expenditure of judicial resources.

CONCLUSION

The Petition for Writ of Certiorari should be denied.

Respectfully submitted,

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October 28, 1993

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APPENDIX

APPENDIX

STATUTORY PROVISIONS

Virginia Code § 38.2-3407

A. One or more insurers may offer or administer a health benefit program under which the insurer or insurers may offer preferred provider policies or contracts that limit the numbers and types of providers of health care services eligible for payment as preferred providers.

B. Any such insurer shall establish terms and conditions that shall be met by a hospital, physician or type of provider listed in § 38.2-3408 in order to qualify for payment as a preferred provider under the policies or contracts. These terms and conditions shall not discriminate unreasonably against or among such health care providers. No hospital, physician or type of provider listed in § 38.2-3408 willing to meet the terms and conditions offered to it or him shall be excluded. Neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with providers or based on market conditions, or price differences among providers in different geographical areas, shall be deemed unreasonable discrimination. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.

C. Mandated types of providers set forth in § 38.2-3408, and types of providers whose services are required to be made available and that have been specifically contracted for by the holder of any such policy or contract shall, to the extent required by § 38.2-3408, have the same opportunity to qualify for payment as a preferred provider as do doctors of medicine.

D. Preferred provider policies or contracts shall provide for payment for services rendered by nonpreferred providers, but the payments need not be the same as for preferred providers.

E. For the purposes of this section, "preferred provider policies or contracts" are insurance policies or contracts that specify how services are to be covered when rendered by preferred and nonpreferred classifications of providers.

Supreme Court, U.S.
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No. 93-510

In The
Supreme Court Of The United States
October Term, 1993

AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,
Petitioners,

v.

STUART CIRCLE HOSPITAL CORPORATION,
Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

BRIEF *AMICUS CURIAE*
IN SUPPORT OF PETITIONER

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v.

STUART CIRCLE HOSPITAL CORPORATION,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

MOTION OF CIGNA CORPORATION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

Pursuant to Rule 37.2 of the Rules of this Court, *amicus*, CIGNA Corporation ("CIGNA") hereby moves for leave to file the attached brief *amicus curiae*. Petitioners have granted but respondent has refused to grant consent for CIGNA to file a brief *amicus curiae* in support of the petition.

CIGNA, through its subsidiaries, operates the largest investor-owned managed care organization in the United States. Based on CIGNA's experience, managed care provides a viable means of restraining rapidly increasing health care costs through marketplace competition, while assuring quality of care. The Fourth Circuit decision in this case is anti-managed care and anti-health care reform. It undermines the ability of insurers to offer managed care plans that can effectively control health care costs and to compete effectively with HMOs and self-insured managed care plans. By requiring insurers to include any willing providers in preferred provider arrangements, marketplace competition, consumer choice and access to care are all adversely affected.

CIGNA believes that it is in a position to bring to this Court's attention relevant matters that could not be brought fully to the Court's attention by petitioner and that respondent is unlikely to bring to the Court's attention. CIGNA therefore respectfully requests leave to file the attached brief *amicus curiae*.

October, 1993

Respectfully submitted,

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BRIEF *AMICUS CURIAE* IN SUPPORT OF PETITIONER

Pursuant to Rule 37.2 of the Rules of this Court, *amicus*, CIGNA Corporation ("CIGNA") hereby submits the following brief *amicus curiae*.

INTEREST OF CIGNA CORPORATION

CIGNA, through its subsidiaries, operates the largest investor-owned managed care organization in the United States with 2,616,714 participants in its various health maintenance organizations ("HMOs") and preferred provider

arrangements ("PPOs") nationwide. In Virginia, CIGNA has more than 130,000 participants in its HMOs and PPOs.

Managed care is the centerpiece of the health care reform plan proposed by the President of the United States, as well as the other key reform proposals pending before Congress. CIGNA is deeply committed to managed care as a means of controlling health care costs. Managed care controls health care costs by integrating both the financing and delivery of health care services through: (1) selective contracting with a limited number of providers who will furnish services to participants at a discounted rate; (2) ongoing quality assurance and utilization management programs; and (3) financial incentives for participants to utilize the selectively contracted providers. By undermining the ability to selectively contract and thereby control costs, "any willing provider" laws, such as that found in Va. Code Ann. §38.2-3407 (1993), have a profoundly negative impact on managed care organizations such as CIGNA.

ARGUMENT

PPOs and HMOs have developed in response to the demand from employers and consumers to control rising health care costs associated with traditional fee-for-service ("indemnity") plans. These managed care programs have been successful in reducing costs for both employers (lower premiums) and consumers (lower co-payments, deductibles and premium contributions), making more generous plan coverage possible. Based on CIGNA's internal data, the annual premium cost for indemnity plans is 20-60% more than that of managed care plans utilizing selectively contracted provider networks. In addition, the benefit package under managed care plans is typically 10-15% richer

than that of indemnity plans, resulting in better health care coverage for consumers at lower out-of-pocket costs.

The key to the success of managed care programs is the ability to limit, through selective contracting, the number of providers to the level required to meet the needs of the enrolled population. The ability to selectively contract with providers results in lower costs for several reasons: (1) providers' willingness to negotiate discounts off the cost of their services is dependent upon the patient volume that the managed care plan can deliver; (2) administration costs are lower if there are fewer providers to deal with; and (3) utilization costs are lower because only the most efficient providers are included and it is easier to monitor utilization of a smaller number of providers.

Selective provider contracting also facilitates efforts by managed care organizations to assure the quality of care. It is easier to monitor treatment patterns, conduct provider education, enforce practice protocols and utilization review standards, perform credentialing functions and monitor member satisfaction with a smaller number of providers that share the managed care organization's objectives in assuring quality of care.

In 1991, the Wyatt Company ("Wyatt") was commissioned by the Health Insurance Association of America to study and estimate the costs associated with six legislative mandates, including mandates that "any willing provider" be allowed to join a managed care network. In its report entitled *Cost Analysis of State Legislative Mandates on Six Managed Health Care Practices* (June 7, 1991), Wyatt concluded that increasing provider panel size impairs the ability of a PPO to reduce costs even to the point where there

are no cost savings at all (*see* pp. 5, 14, 23). In addition, "the 'any willing provider' mandate makes it extremely difficult for a PPO to limit provider participation while still making the criteria flexible enough to attract the right providers" in terms of quality and demographic spread (*see* p. 23).

Although the Virginia General Assembly appears to recognize the value of insured PPOs by its enactment of §38.2-3407, the "any willing provider" provision of this statute, which applies only to insurers, negates the ability of insurers to provide quality care and effectively manage costs through preferred provider arrangements. Insurers are, thus, unfairly denied the opportunity to compete on a level playing field with HMOs and self-insured plans which are not subject to this provision and free to selectively contract with providers. Denying insurers the opportunity to compete effectively with HMOs and self-insured plans also results in fewer choices for consumers. In addition, it has the adverse effect of encouraging the development of self-insured managed care arrangements which are beyond the pale of insurance regulation. As a consequence, consumers lose the protection of such regulation, including mandated benefits and solvency protection.

"Any willing provider" laws also have the socially undesirable effect of encouraging providers to continue practicing in highly saturated areas rather than practicing in areas with medically underserved populations. If managed care organizations can, through selective contracting, limit their networks to the number of providers actually needed to serve their participants, some providers will be encouraged to establish practices in underserved areas. By encouraging providers to practice in already overserved areas, "any willing

provider" laws do a disservice to consumers in medically underserved areas. In addition, overutilization of services is more probable in overserved areas.

SUMMARY OF ARGUMENT

The "any willing provider" mandate in Virginia's PPO statute is anti-competitive and anti-consumer. Although it appears on its surface to protect consumer choice, it actually reduces consumer choice by precluding insured PPOs from competing in the health care marketplace. It also has the effect of promoting unregulated, self-insured managed care arrangements and discouraging the distribution of health care providers to medically underserved areas.

CONCLUSION

For the foregoing reasons, CIGNA respectfully requests the Court to grant the Petition for Writ of Certiorari of Aetna Life Insurance Company and Aetna Health Management and set the case for plenary review.

October, 1993

Respectfully submitted,

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,

Petitioners,

—v.—

STUART CIRCLE HOSPITAL CORPORATION,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE FOURTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF FOR METROPOLITAN LIFE INSURANCE COMPANY AS AMICUS CURIAE AND BRIEF AMICUS CURIAE IN SUPPORT OF PETITIONERS

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ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE FOURTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF FOR METROPOLITAN LIFE INSURANCE COMPANY AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

Metropolitan Life Insurance Company ("MetLife") hereby moves, pursuant to Rule 37.2 of the Rules of this Court, for leave to file the attached brief as *amicus curiae*. Counsel for the petitioner has consented to the filing of this brief; counsel for the respondent has denied consent.

MetLife is one of the largest group insurers and claims administrators in the United States. Many of its customers conduct business national in scope and provide benefits to employees located in virtually every state of the United States. MetLife, for the benefit of those customers and their employees, supports and maintains preferred-provider networks or programs in Virginia and across the country. A substantial portion of the day-to-day decisions MetLife makes are therefore subject to federal-question jurisdiction under the Employee Retire-

ment Income Security Act of 1974, as amended ("ERISA"), because they relate to employee welfare benefit plans within ERISA's ambit. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 67 (1987).

MetLife, as an insurer affected by ERISA, has steadfastly sought to preserve the intent of Congress in enacting ERISA, as evidenced by the preceding legal citation. Congress intended ERISA to eliminate the need for employers to design employee welfare benefit plans according to a varying patchwork of state regulation. 3 Legislative History of the Employee Retirement Income Security Act of 1974 at 4673 (1976). Toward that end, it gave ERISA one of the broadest pre-emption clauses contained in any federal statute. ERISA pre-empts any state law which "relate[s] to *any* employee benefit plan" not explicitly exempt from ERISA. ERISA § 514(a) (emphasis added). While it saves from pre-emption state laws which "regulate[ ] insurance," ERISA § 514(b)(2)(A), it does so narrowly, without compromising the "conspicuous" breadth of the pre-emption clause. *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990).

The central issue in this case—whether Virginia's any-"willing"-provider law is saved from ERISA pre-emption—is one in which MetLife is vitally interested. Under the Virginia statute, if a health care provider is "willing" to enter into a contractual relationship with an insurer that establishes a preferred-provider program, then the provider must be allowed to enter into that relationship, unless "[ ]reasonable discrimination" can be shown. *See* VA. Code Ann. § 28.1-2307(A), (B). The Fourth Circuit held that the statute—which mandates a contractual relationship between two business entities, one of which happens to be an insurer—regulates insurance and is therefore saved from ERISA pre-emption. 995 F.2d at 505. Because MetLife, for the reasons set forth in the attached brief *amicus curiae*, firmly believes that Virginia's any-"willing"-provider law does *not* regulate insurance but inhibits the ability of plan sponsors to engage in creative, uniform ERISA plan design,

MetLife asks this Court to grant this motion for leave to file the attached brief, in support of the Petition.

Dated: October 28, 1993

Respectfully submitted,

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QUESTION PRESENTED

Is Virginia's any-"willing"-provider law saved from ERISA pre-emption because it "regulates insurance," as that phrase has been interpreted by controlling precedent of this Court, or, because it *fails* to "regulate[ ] insurance," does ERISA in fact pre-empt it?

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BRIEF AMICUS CURIAE FOR METROPOLITAN LIFE INSURANCE COMPANY IN SUPPORT OF PETITIONERS

INTEREST OF AMICUS

MetLife has one of the largest preferred-provider programs in the nation and operates a preferred-provider program in the State of Virginia. That program functions according to a universally-accepted premise: Some providers are willing to supply services to patients at lowered rates in exchange for the presumption of increased volume. Conversely, some beneficiaries of group health insurance contracts are willing to forgo utilization of their usual provider in favor of a "preferred provider" if the cost to them of doing so will be reduced.

In a preferred-provider program, it is a truism that the volume handled by each provider increases when there are fewer

providers to choose from. The larger the number of providers in a particular geographical area, the less likelihood there is that any particular provider will be chosen by the beneficiaries who reside in that locale, and the less inducement there will be for local providers to exchange lowered rates for the presumption of increased volume. Indeed, if, under the statute challenged here, all local providers were to participate voluntarily in such a program, the cost-control aspect of the program would, in the end, fail. With elimination of the presumption of increased volume, the reason for joining the program would cease to exist. Under the latter scenario, such a program could continue only if all providers were required to supply services at a reduced rate, regardless of volume.

The ruling of the Fourth Circuit Court of Appeals in *Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d 500 (1993), which wrongly interpreted section 38.2-3407 of the Virginia Code, gives providers the best of both worlds and insurers the best of none. Providers are not required to supply their services at a reduced rate, but insurers are required to admit them to their preferred-provider networks, whether or not they would otherwise be accepted, thereby diluting the potential to generate volume and cost savings through a limited preferred-provider program. In the end, the Fourth Circuit's decision, which conflicts with prior decisions of this Court, gives providers the means of destroying the very networks which the Virginia Code purports to authorize by undermining the rationale of such networks and inhibiting sponsors of ERISA plan from engaging in effective plan design. Because MetLife believes that no such result is required or permitted under ERISA, it submits this brief in support of the petition.

REASONS FOR GRANTING WRIT

A. The Decision of the Fourth Circuit Impermissibly Expands ERISA's Saving Clause at the Expense of its Pre-Emption Clause, in Contravention of Controlling Precedent of This Court.

This Court should issue a writ of *certiorari* to the United States Court of Appeals for the Fourth Circuit because the latter's opinion in *Stuart Circle v. Aetna* has decided a federal question, restricting the scope of ERISA's pre-emption clause, in a way which conflicts with controlling decisions of this Court. *See* Sup. Ct. Rule 10.1(c).

The extent to which ERISA pre-empts "any and all State laws" that "relate to" an ERISA plan is a federal question. See ERISA § 514(a); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 67 (1987). This Court has previously decided that ERISA's pre-emption clause is "conspicuous" for its breadth and must be broadly construed, to the fullest limits. *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990); *see also Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47-48 (1987).

Although ERISA "saves" from pre-emption those state laws which "regulat[e] insurance, banking, or securities," § 514(b)(2)(A), in comparison to the "all-inclusive pre-emption provision," the savings-clause exceptions are "specific" and "narrow." *Shaw v. Delta Air Lines*, 463 U.S. 85, 104 (1983). Prior precedent of this Court therefore requires that the *pre-emption* clause be *broadly* construed while the "*saving*" clause be given a "*narrow*" reading, limited to its specific exceptions. *Pilot Life*, 481 U.S. at 47-48; *Shaw*, 463 U.S. at 104 (emphasis added). To ensure that dichotomy of treatment, this Court has developed two tests which state laws purporting to "regulat[e] insurance" must pass or they will not be saved from ERISA pre-emption: (1) the "common-sense" test; and (2) the McCarran-Ferguson Act test. *Pilot Life*, 481 U.S. at 48-49. By wrongly finding that Virginia's any-"willing"-provider law sat-

isfies both tests, 995 F.2d at 503, the Fourth Circuit "broadly" construed ERISA's "saving" clause at the expense of its pre-emption clause, in contravention of this Court's controlling precedents.

According to this Court, common sense dictates that "in order to regulate *insurance* [and, as a result, be saved from ERISA pre-emption], a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." *Pilot Life*, 481 U.S. at 50. As this Court observed in *Pilot Life*, if a law having an impact on the insurance industry nevertheless has its roots "firmly planted in the general principles of . . . tort *and contract law*," it will fail to satisfy the common-sense test. 481 U.S. at 50 (emphasis added). The Fourth Circuit nevertheless declared that Virginia's any-"willing"-provider law *had* satisfied the common-sense test because "it regulates *certain insurance contracts*, albeit indirectly[.]" 995 F.2d at 503.

What the Fourth Circuit neglected to point out is that the true focus of Virginia's any-"willing"-provider law is *providers*, not insurers. Because the statute requires an insurer to enter into a contract with *any provider* "*willing* to meet [its] terms and conditions" (notwithstanding the statute's claim that an insurer may "limit" the number of providers with which it may contract), the statute gives *providers* a right they would not ordinarily have, absent the statute. VA. Code Ann. § 28.1-2307(A), (B) (emphasis added). By mandating a contractual relationship between parties where no meeting of the minds would otherwise occur, the roots of this Virginia statute extend directly into general principles of *contract* law, not insurance law, as did the Mississippi law of "bad faith" pre-empted in *Pilot Life*. *See* 481 U.S. at 50. Nothing commonly thought of as "*insurance*" or an "*insurance* contract" results from an insurance company entering into a contract with a health-care provider to supply services at a specified rate, or from a provider obtaining a guaranteed right to enter into such a contract with an insurer, any more than "insurance" would result from a statutorily-man-

dated purchase of paper clips from a company willing to match the price of an insurer's existing vendor. As a matter of "common sense," the Virginia statute doesn't "regulat[e] insurance," it regulates the contractual relationship between two business entities, one of which happens to be an insurer. As a matter of common sense, Virginia's any-"willing"-provider law therefore falls outside the "narrow" scope of ERISA's saving clause. *Shaw*, 463 U.S. at 104; ERISA § 514(b)(2)(A). It is preempted. *Pilot Life*, 481 U.S. at 50; ERISA § 514(a).

Virginia's any-"willing"-provider law also fails to satisfy any prong of the McCarran-Ferguson Act test. To satisfy that test, the law in question must (1) transfer or spread *policyholder risk*; (2) be integral to the policy relationship between the *insurer* and the *insured*; and (3) relate to a "practice" which is limited to entities within the insurance industry. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743 (1985).

No risk to any policyholder (or plan participant) is spread by the Virginia statute. The statute does not *require* insurers to offer participants the benefits of a preferred provider program, it only specifies that *if* the insurer has such a program, then provider X, if willing, must be given the same contractual opportunity to provide services to plan participants as provider Y. VA. Code Ann. § 28.1-2307(B). The fact that X rather than Y might be the provider of services (even if supplied at a reduced rate) does not spread anyone's *risk* of loss, it merely explains who the provider can or will be. *See Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129-130 (1982).

Furthermore, while this Court has held that health-care benefits mandated by law *do* spread or transfer policyholder risk within the meaning of the first prong of the McCarran-Ferguson Act test, *Metropolitan v. Massachusetts*, 471 U.S. at 744, the Virginia statute does not mandate a benefit to any *plan participant*. A "mandated benefit" is "a certain *kind* of benefit" (such as benefits for mental hygiene) which an insurer must

provide to the *beneficiaries* of an *insurance* contract, under all circumstances. 471 U.S. at 728-30.

The Virginia any-"willing"-provider law operates in a completely different way. It mandates no *kind* of benefit to the beneficiaries of group insurance contracts. Indeed, it is entirely conceivable that, after application of the Virginia statute, one beneficiary could go to his or her chosen provider and obtain covered services from a "preferred provider" at a reduced rate while another beneficiary of the same contract could go to his or her chosen provider and obtain covered services but be required to pay full cost. Why? Because the participant's ability to benefit from application of the Virginia statute turns on the *whim of the provider* in being "willing" to enter into a preferred provider agreement with the insurer. The statute does not mandate *anything* with respect to the intended third-party beneficiaries of a group insurance contract. Rather, it mandates a contractual relationship between insurers and certain providers who are *not* the intended third-party beneficiaries of any such contract. Hence, the Virginia statute fails to transfer any risk, whether one performs traditional risk analysis or analyzes the statute as a mandated-benefit law under the controlling precedent of *Metropolitan v. Massachusetts*.

Nor does Virginia's any-"willing"-provider law affect the relationship between the insurer and *the insured*, as evidenced by the caption to this lawsuit where only the names of a hospital and an insurer appear. Health care *providers*—not plan participants—have sued to obtain what they argue are *their* mandated rights. The law at issue clearly affects the relationship between the *insurer* and the *provider*, not the insurer and the insured.

Finally, although the Virginia any-"willing"-provider law purports to focus on the insurance industry, the practice of entering into contracts with providers is hardly a "practice . . . limited to entities within [that] industry." *See Pilot Life*, 481 U.S. at 51. The crux of the matter here is the contractual

relationship between one group of business people—*providers*—and those from another business—in this case, insurers. Entering into contractual relationships with providers is a "practice" no more limited to the insurance industry than was the bad-faith law pre-empted in *Pilot Life*. *Id.* Hence, the Virginia any-"willing"-provider law fails to satisfy any prong of the McCarran-Ferguson Act test and is not saved from ERISA pre-emption. *See Pilot Life*, 481 U.S. at 50-51.

B. The Decision of the Fourth Circuit Impermissibly Inhibits ERISA Plan Design, While Congress, in Enacting ERISA, Sought to Avoid the Kind of Piecemeal State Regulation Which the Fourth Circuit's Decision Promotes.

There is, ultimately, another over-arching reason why Virginia's any-"willing"-provider law should be pre-empted. That law attempts to regulate ERISA plan design, not to mandate benefits. ERISA was intended to *eliminate* the need for plan sponsors "to design their programs in an environment of differing State regulations . . . ." *FMC Corp.*, 498 U.S. at 60. It is important to keep that objective in mind, particularly when the saving clause is utilized to limit plan design in a way which Congress never intended, for "in interpreting the saving clause, [courts are obliged] to consider [its] role . . . in [the context of] ERISA as a whole." *Pilot Life*, 481 U.S. at 51.

The statute here in question limits an insurer's ability to design an efficacious plan yet fails to pass the tests, established by this Court, which show that it should be "saved" from the broad sweep of ERISA pre-emption. In the greater context of what Congress hoped to achieve by enacting ERISA, that statute not only "relate[s] to" an ERISA plan but is precisely the kind of overreaching statute which ERISA was designed to pre-empt. *Pilot Life*, 481 U.S. at 51-52; *Shaw*, 463 U.S. at 104.

CONCLUSION

Under controlling precedent of this Court, Virginia's any-"willing"-provider law fails to "regulate[ ] insurance" and therefore is pre-empted, without being saved. Because the Fourth Circuit, in *Stuart Circle*, found that Virginia's any-"willing"-provider law was "saved" from ERISA pre-emption, it should be *reversed*.

October 28, 1993

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Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

MOTION OF THE GROUP HEALTH ASSOCIATION OF AMERICA, INC. FOR LEAVE TO FILE BRIEF AMICUS CURIAE AND BRIEF AMICUS CURIAE IN SUPPORT OF PETITIONERS

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MOTION OF THE GROUP HEALTH ASSOCIATION OF AMERICA, INC. FOR LEAVE TO FILE BRIEF AMICUS CURIAE IN SUPPORT OF PETITIONERS

Pursuant to Rule 37.2 of the Rules of this Court, *amicus*, the Group Health Association of America, Inc. ("GHAA") hereby moves for leave to file the attached brief *amicus curiae*. Petitioners have granted but respondent has refused to grant consent for GHAA to file a brief *amicus curiae* in support of the petition.

GHAA and its member companies have been active participants in efforts to convince the legislatures of the several States not to enact laws that prohibit or thwart health maintenance organizations (HMOs), preferred provider organizations (PPOs) and similar managed care organizations from contracting with the health care practitioners, facilities and vendors of their choice. These "any willing provider" laws interfere with the

cost-effective delivery of health care services by HMOs and PPOs to their enrolled members. GHAA believes that it is in a position to bring to this Court's attention relevant matters that could be brought fully to the Court's attention by petitioners and that respondent is unlikely to bring to the Court's attention.

In particular, GHAA brings to the Court's attention in the attached brief information which explains that the enactment of "any willing provider" laws by a growing number of States is undermining the concept and structure of managed care as implemented by HMOs and PPOs. More than 30 laws have been enacted in 20 of the States to restrict the ability of HMOs to contract exclusively with the providers of their choice. In 1993, more than 60 any willing provider bills were introduced by the legislatures of 30 States. To date, more than thirteen of these measures in as many States have been enacted this year. GHAA believes that the magnitude of the legislative initiative in the States to enact "any willing provider" laws and the implications this trend may have on health care quality and costs should be fully understood by the Court as it considers whether to grant review of this case.

GHAA therefore respectfully requests leave to file the attached brief *amicus curiae*.

October 29, 1993

Respectfully submitted,

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QUESTION PRESENTED

Did the Court of Appeals err by holding that Virginia's "any willing provider" law regulates insurance and is thus saved from ERISA preemption?

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INTEREST OF AMICUS CURIAE

Pursuant to Rule 37 of the Rules of this Court, Group Health Association of America, Inc. ("GHAA") files this brief as *amicus curiae* in support of the petition for writ of certiorari.[1]

GHAA, founded in 1959, is the largest and oldest trade association for health maintenance organizations ("HMOs"). Membership in GHAA is open to all prepaid health care organizations that meet GHAA's standards for quality assur-

[1] A motion for leave to file this brief amicus curiae is filed simultaneously with this brief because petitioners have granted but respondent refused to grant consent.

ance, financial solvency, and comprehensiveness of benefits. GHAA's 350 member companies enroll over 30 million people, close to three-quarters of the more than 41.4 million Americans receiving health care coverage through HMOs. GHAA's members include independent locally-based non-profit and for-profit HMOs, HMOs operated by national HMO firms, subsidiaries of Blue Cross and Blue Shield plans, and subsidiaries of major insurance organizations.

HMOs provide or arrange for the provision of health care services to their members. They do so in various ways. Some employ staff physicians. Some contract with individual physicians as independent contractors. Others contract with medical group practices or with associations of individually practicing physicians. Some HMOs may use a combination of those methods. However, all HMOs, through whatever method adopted, provide or arrange for the provision of health care services to members through an established network of selected health care providers. This is in contrast to traditional indemnity health benefit plans, which generally indemnify enrollees for any medically necessary covered health care services without regard to the provider of those services.

HMO have demonstrated success in delivering high quality health care in a cost-effective manner. In 1992, according to a study by A, Foster Higgins, an employee benefits consulting firm, employees paid 23.2% less per employee per year for HMO coverage than for traditional health insurance—$3,313 per employee for HMO coverage versus $4,080 per employee for indemnity coverage. In addition to the lower costs, HMOs offer excellent comprehensive benefits, benefits often not avaliable under traditional indemnity plans. According to GHAA's 1992 national survey of HMOs, virtually all HMOs provided primary care, hospitalization and a variety of preventive services, including well-baby care, prenatal care, well-child care, pap tests, mammography and childhood immunization.

The quality and cost-effectiveness of HMOs has resulted in a tremendous increase in HMO enrollment over the last several years. Total HMO enrollment in 1992 was 41.4 million, more than quadruple the number of enrollees in 1980.

HMOs are one form of what is known as managed care. "Managed care" refers to arrangements that integrate the financing and delivery of health care. The goal of managed care is to promote more cost-effective delivery of health care.

The Virginia law at issue in this case regulates preferred provider organizations ("PPOs"), another form or managed care. Although PPOs differ from HMOs in important respects, they share one very important characteristic—in order to operate effectively, they must selectively contract with a *limited* number of health care providers who agree to provide health care services to plan enrollees according to agreed upon terms and conditions. These terms and conditions include price discounts on health care services.

The Virginia law at issue in this case is commonly referred to as an "any willing provider" law. Such laws restrict the ability of managed care organizations to contract selectively with health care providers by requiring that the managed care organization include in the network any provider willing to meet the terms and conditions established by the managed care organization. The selection of appropriate providers is a key component in creating a cost-effective managed care organization. "Any willing provider" laws severely compromise the ability of a managed care organization to select the providers it wants and greatly undermine the ability of managed care organizations to deliver high quality, cost-effective health care services.

The careful selection of a limited network of providers is essential to the cost-effective operation of an HMO. Selective contracting allows the HMO to negotiate favorable financial arrangements with providers. The HMO can assure the selected providers an increase in patient volume, and guarantee prompt payment, in exchange for the providers' agreement to accept discounted compensation. In essence, selective contracting

encourages providers to compete to provide medical services to HMO members. Only by choosing a *limited* number of providers can the HMO assure the necessary increase in patient volume that will induce and allow the selected providers to offer meaningful price reductions.

It is this competitive dynamic which is destroyed by "any willing provider" laws. By allowing providers to sit back and decide after the fact whether they wish to meet the terms established by the managed care organization, providers have no incentive to compete for inclusion in the network.

The Federal Trade Commission has recognized the procompetitive effect of limited provider networks. *See*, letter from the Acting Director of the FTC's Office of Consumer and Competition Advocacy to the Attorney General of the State of Montana attached as Exhibit E to the Petition for Writ of Certiorari.

Federal courts have also found that limited provider networks are effective in controlling health care costs. For example, among the *findings of fact* in *HCA Health Services* v. *Metropolitan Life Ins. Co.*, 752 F. Supp. 202, 204 (E.D. Va. 1990), a case involving the same statute at issue in this case, were that "[i]t is by limiting the number and types of providers included in a PPO that an insurer is able to implement cost reductions in services for health beneficiaries" and that "[t]he establishment of PPOs has helped to stem the tide of steadily increasing health care costs in this country." The Seventh Circuit Court of Appeals recognized in *Ball Memorial Hosp., Inc.* v. *Mutual Hosp. Ins., Inc.*, 784 F.2d 1325, 1343 (7th Cir. 1986) that "[t]he requirement that hospitals bid in order to get the plan's business is the principal source of the incentive to cut costs. . . ."

Selective contracting also lowers administrative costs for the managed care organization. When an appropriate number of providers is in the network, the initial contracting costs and the ongoing cost of administration of the network are lower than when a larger and excessive number of providers must be contracted with.

Selective contracting helps to assure the quality of health care provided through the HMO. Selected providers must meet credentialling and other quality assurance requirements in order to participate in HMO provider networks.

Selective contracting ultimately contributes to expand health care consumer choice. Notwithstanding the usual stated rationale for "any willing provider" laws—that they assure that health care consumers will have greater "choice" of providers—"any willing provider" laws actually restrict consumer choice. By undermining the cost efficiencies of PPOs and HMOs, they make it considerably less likely that such arrangements will be made available to health care consumers.

There is already a well-established trend in the States to enact "any willing provider" legislation affecting HMOs. More than 30 such laws in 20 of the States restrict the ability of HMOs to establish or maintain exclusive provider networks. During 1993, more than 60 such proposals were introduced in the legislatures of 30 of the States. Of these proposals, at least 13 in as many States became law. The unabated continuation of this trend will mean that consumers' choice of health plans may ultimately be limited to traditional indemnity plans for health care coverage.

The decision of the Court of Appeals will likely be looked to by other courts presented with the issue of whether a State's "any willing provider" law is preempted by ERISA. GHAA submits this *amicus curiae* brief to highlight the great importance of this case to the ability of HMOs and other managed care organizations to deliver high quality, cost-efficient care.

REASONS FOR GRANTING THE WRIT

I. INTRODUCTION

This case represents a critical issue from both a legal and a broader societal perspective. Whether or not the Virginia "any willing provider" law is preempted by ERISA presents this

court with an opportunity to define the scope of ERISA preemption as it relates to a critical feature of an increasing number of employee health benefit plans. From a broader perspective, a decision by this Court on this issue will determine whether ERISA plans will have the flexibility to design plans to take full advantage of an effective tool for controlling health care costs or whether those plans will be subject to unnecessary and burdensome regulation by the States.

II. THE COURT OF APPEALS ERRED IN HOLDING THAT THE VIRGINIA "ANY WILLING PROVIDER" LAW REGULATES THE BUSINESS OF INSURANCE AND IS THUS SAVED FROM ERISA PREEMPTION

The Court of Appeals erred in holding that the Virginia "any willing provider" law is saved from ERISA preemption as a law regulating insurance. This Court has held that only laws that regulate the "business of insurance," as that term of art has been interpreted under the McCarran-Ferguson Act, are saved from preemption. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). This court has also held that selected contracting by a health insurer with health care providers does not constitute the "business of insurance" under the McCarran-Ferguson Act. *Group Life & Health Ins. Co. v. Royal Drug*, 440 U.S. 205 (1979). It is therefore impossible to reconcile the Court of Appeals' decision with this Court's precedents. Moreover, the influence that a decision by the Court of Appeals will have on other courts faced with the same issue, combined with the large and growing number of state "any willing provider" laws, will negatively impact the ongoing efforts of managed care organizations to control health care costs.

The fundamental error made by the Court of Appeals was its confusion of the *practice* being regulated—the selection of preferred providers—with the *entity* being regulated—insurance companies. The blurring of this distinction—the very distinction critical to the McCarran-Ferguson analysis—poses a grave

danger to the availability of managed care benefits under employee welfare benefit plans.

The most glaring evidence of the failure of the Court of Appeals to make that crucial distinction is its discussion of the third part of the McCarran-Ferguson analysis. In order for the third prong of the McCarran-Ferguson test to be met, a court must determine "whether the *practice* is limited to entities within the insurance industry." *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982) (emphasis added). The Court of Appeals concluded that "[t]he Virginia statute also satisfies the third criterion. *It* is expressly 'limited to entities within the insurance industry.' " *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 955 F.2d 500, 504 (4th Cir. 1993) (emphasis added). Of course, the "it" referred to by the Court of Appeals is the statute, whereas the "it" that the Court of Appeals should have considered was the *practice* of selecting preferred providers. Thus, the Court of Appeals is saying that because the statute regulates "entities within the insurance industry," *i.e.*, insurance companies, it regulates the "business of insurance." Yet that is precisely the analysis *rejected* by this Court both in *Royal Drug* (holding that provider contracting is not the business of insurance) and in *Pireno*, when it held that *not* every practice engaged in by an insurance company is the business of insurance.

The concern of managed care organizations such as HMOs is that the Court of Appeals' expansion of the concept of the business of insurance will sanction growing regulation by the States of the establishment of uniform managed care benefits under employee welfare benefit plans and thereby undermine the purposes and objectives of ERISA.

Conclusion

The decision of the Court of Appeals is an unwarranted expansion of the insurance saving clause of the ERISA preemption provision. It sanctions the disturbing trend of regulation by the States of managed care provider networks by enactment of "any willing provider" laws. These laws are demonstrably anticompetitive and anticonsumer, and have the effect of raising health care costs. It is critical that this Court review the clearly erroneous decision of the Court of Appeals, which is irreconcilable with this Court's decisions in *Pilot Life*, *Metropolitan Life v. Massachusetts*, and *Royal Drug*, so that managed care organizations can continue to provide high quality, cost-effective care by contracting selectively for the services of appropriate providers of care.

October 29, 1993

Respectfully submitted,

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In The

Supreme Court of the United States

October Term, 1993

AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,

Petitioners,

v.

STUART CIRCLE HOSPITAL CORPORATION,

Respondent.

MOTION FOR LEAVE TO FILE AND BRIEF OF THE CONNECTICUT BUSINESS AND INDUSTRY ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

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Pursuant to Rule 37.2 of the Rules of this Court, the Connecticut Business and Industry Association ("CBIA") respectfully moves for leave to file the accompanying brief amicus curiae in this case. Counsel for the Petitioners has consented to the filing of a brief, amicus curia, but counsel for the Respondent has refused such consent. Petitioner moves for leave to file the accompanying brief notwithstanding such refusal.

Interest of Amicus

The Connecticut Business and Industry Association is the largest business and trade association in the State of Connecticut having approximately 7,000 members who employ a total work force of over 700,000 employees. CBIA presents the view of

its members on public policy and legal issues to legislative and judicial authorities.

Petitioner's request Certiorari to overturn a decision of the United States Court of Appeals for the Fourth Circuit. CBIA agrees with the Petitioner that the decision of the Court of Appeals should be overturned.

CBIA's principal interest lies in having this Court limit the scope of the ERISA[1] saving clause contained in 29 U.S.C. §1144(b)(2)(A) so as not to make the general principal of federal preemption to plans subject to ERISA meaningless when applied to matters concerning group health insurance. Such state laws, if not limited in

---

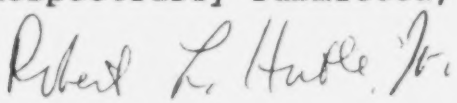
1 The Employee Retirement Security Act of 1974, as amended (ERISA), codified at 29 U.S.C. §1001, et seq.

scope by the application of federal preemption, force employers such as those represented by CBIA to offer more costly group health insurance plans solely because, by law, such plans must include inefficient providers of medical service that otherwise would have been unable to exist in the competitive marketplace.

Legislation similar to that adopted by Virginia, and which is at issue in this case, has been introduced in the Connecticut legislature and CBIA has opposed the enactment of such legislation. CBIA understands that similar legislation may be introduced in other states and this trend affects employers such as those represented by CBIA, and most importantly such member-participants' employees.

For all of the foregoing reasons, the Connecticut Business and Industry Association respectfully moves for leave to file the accompanying brief as amicus curiae.

Respectfully submitted,



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INTEREST OF THE AMICUS CURIAE

The Connecticut Business and Industry Association (CBIA) is the largest business and trade association in the State of Connecticut having approximately 7,000 members who employ a total work force of over 700,000 employees. CBIA presents the view of its members on public policy and legal issues to legislative and judicial authorities.

REASONS FOR GRANTING THE WRIT

Summary of Argument.

CBIA believes that the decision of the Fourth Circuit Court in this matter, if not overturned, may result in the adoption in Connecticut and other states of statutes similar to the statute at issue in this case which will force employers such as those

represented by CBIA to be offered group health insurance plans which are more costly simply because inefficient providers are required under state law to be admitted into the service provider network. This could not be an intended result of the ERISA statute.

Argument.

This brief does not deal with the legal intricacies of the ERISA preemption rules which are well stated in the Petitioner's brief. By this brief CBIA merely seeks to bring to the Court's attention the economic implications which may result from the affirmance of the decision of the Court of Appeals in this matter.

CBIA represents many employers who provide group insurance coverage to their employees. In many instances employers utilize group health plans

which contract with service providers for fees which would not ordinarily be obtainable on a single employer or even small multi-employer group basis. The economies of scale relating to administrative costs and the enhanced bargaining power in the marketplace of these large-scale groups allow them to negotiate with service providers for reduced rates.

Those reduced rate services contracts are the basis for the group insurer's ability to control costs and, therefore, the premium which must be charged to employers. Those premiums are frequently charged to a member's employees via payroll deduction.

In turn, those providers who join with the group insurer by offering reduced rate services are able to maximize their profits through

increased volume and the efficient delivery of medical services. Only through the limitation on the number of service providers in any one geographic area may the volume be sufficient to experience the economies of scale necessary to keep the unit cost of the service supplier down to a profitable level taking into account the fee which the group insurer is willing to pay for such service.

In support of its position, CBIA makes reference to a study by the Wyatt Company dated June 7, 1991 entitled Report to Health Insurance Association of America, Cost Analysis of State Legislative Mandate on Six Managed Health Care Practices which concludes that enactment of "any willing provider" statutes such as the one presently before this Court serves to

increase administrative costs as the size of the provider network increases and that such increases may be in the range of 170% above the baseline cost of a limited network system.

Also, CBIA makes reference to a letter of Mr. Michael O. Wise, Acting Director of the Federal Trade Commission, dated February 4, 1993 and addressed to the Honorable Joseph P. Mazurek, Attorney General of the State of Montana reproduced at Appendix E of the Petitioner's Petition for Writ of Certiorari. That letter summarizes the findings of a study authorized by the Commission and concludes that the Montana "any willing provider law", (Mont Code Ann., Title 33 Ch. 22 Part 17 (1991)), discourages competition among providers, and in turn raises prices to consumers and unnecessarily

restricts consumer choice in prepaid health care, without providing any substantial public benefit.

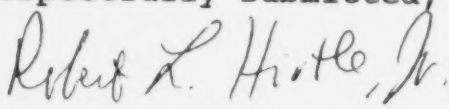
Given the public demand to control the spiraling costs of health care in this country, CBIA's member employers believe the marketplace should be left free of state legislation so as to allow employers and employees to experiment with different types of health care delivery systems. The imposition of state controls such as an "any willing provider" statute, which will have the effect of increasing the costs of such systems, is inconsistent with such a goal. The absence of a federal rule in this area coupled with a finding of preemption will ensure that the marketplace will be allowed to develop the most efficient and lowest

price health insurance plans. For that reason, the decision of the court below should be reversed.

Conclusion.

For the reasons set forth above, CBIA respectfully requests that this Court grant the petition for Writ of Certiorari and overturn the decision of the Fourth Circuit Court of Appeals in this matter.

Respectfully submitted,



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I hereby certify that on this 29th day of October, 1993, I caused a true and correct copy of the foregoing BRIEF OF THE CONNECTICUT BUSINESS AND INDUSTRY ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PETITIONERS to be served by first class mail, postage prepaid, upon:

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Respondent.

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MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF *AMICUS CURIAE*

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MOTION OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, AMERICAN ASSOCIATION OF PREFERRED PROVIDER ORGANIZATIONS, AND AMERICAN MANAGED CARE AND REVIEW ASSOCIATION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* IN SUPPORT OF THE PETITION

Pursuant to Rule 37.2 of the Rules of this Court, *amici*, the Health Insurance Association of America ("HIAA"), Association of Preferred Provider Organizations ("AAPPO"), and American Managed Care and Review Association ("AMCRA"), hereby move for leave to file the attached brief *amicus curiae*. Petitioner has granted but respondent has refused to

grant consent for *amici* to file a brief *amicus curiae* in support of the petition.

Amici bring a unique and broad perspective to the issue brought before this Court. ERISA preemption and its relation to the Virginia "any willing provider" statute affects most of our collective membership, including large and small insurers and companies operating preferred provider organizations (PPOs) which are neither health care providers nor health insurance carriers.

Amici can bring to this Court's attention relevant matters that could not be brought fully to the Court's attention by petitioner and that respondent is unlikely to bring to the Court's attention. In particular, *amici* point out how the holding of the Fourth Circuit Court of Appeals will, if allowed to stand, inhibit the ability of employee welfare benefit plans to contain and control health care costs through the use of managed care networks.

Amici therefore respectfully request leave to file the attached brief *amicus curiae*.

Respectfully submitted,

/s/ Theresa L. Sorota

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INTERESTS OF THE AMICI

The Health Insurance Association of America ("HIAA"), the American Association of Preferred Provider Organizations ("AAPPO"), and the American Managed Care and Review Association

("AMCRA") submit this *amicus curiae* brief in support of petitioners.[1]

HIAA is a non-profit national trade organization representing over 250 commercial health insurers that provide health care coverage to over 65 million Americans. Many of HIAA's member companies either own, operate, or lease health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), and other entities whose primary purpose is to provide health care services through a managed care system. Approximately 50 percent of all HIAA members offer at least one network-based managed care product. Additionally, more than two-thirds of the total enrollment in commercial insurers' managed care plans are in PPOs. *Insurer-Sponsored Managed Health Care: 1990*, Health Insurance Association of America (1991). Other member insurers, primarily mid-sized carriers, lease PPO networks from other insurers or enter into joint venture agreements with independent PPOs.

AAPPO is a non-profit national trade association representing PPOs, exclusive provider organizations (EPOs), and point of service (POS) plans, and their partners in managed health care. The AAPPO's 1,300 individual members represent 274 PPOs (more PPOs than all other trade associations combined), 53 insurers and more than 300 other organizations actively involved in managed care. The AAPPO represents the fastest growing health care delivery model, and its membership comprises a significant portion of both the delivery systems and recipients of health care in

[1] This brief is being filed with the consent of petitioners and by *amici's* Motion for Leave to File as *amicus curiae*.

the United States. The organization's activities include public and industry education, research, development of industry standards, and advocacy.

AMCRA is a national trade association representing over 500 managed care organizations providing health care to more than 75 million Americans. AMCRA represents the full spectrum of managed care organizations, including HMOs, independent practice associations ("IPAs"), and PPOs. These organizations provide Americans with a choice of health care plans that emphasize the appropriate use of health care facilities and services, resulting in the highest quality of health care at an affordable price.

The ability of the members of HIAA, AAPPO, and AMCRA [hereinafter *amici*] to offer cost efficient, high quality preferred provider networks through employee welfare benefit plans is jeopardized by the decision of the Fourth Circuit, which held that Virginia's "any willing provider" statute, Virginia Code § 38.2-3407, is saved from ERISA preemption as a law that regulates the "business of insurance." *Stuart Circle Hosp. Corp. v. Aetna Health Management; Aetna Life Ins. Co.*, 995 F.2d 500 (4th Cir. 1993). That statute requires that PPO networks accept any provider of health care services willing to meet the network's established criteria. Such a requirement strikes at the heart of the principles of managed care.

PPOs, HMOs, and other variations of managed care organizations are formed in order to deliver quality health care to consumers at a reduced cost. Administrators of these alternative delivery systems, which in many cases are not insurance companies, use selective contracting to negotiate prices with a limited number of providers. These "preferred" providers

typically deliver health care services to employee benefit plan participants at a substantially lower rate than non-network providers in exchange for increased patient volume.

Increased patient volume makes it possible for the provider to benefit by obtaining a larger share of the market. The promise of increased market share allows providers to predict the amount of business they will have and improves economies of scale, both of which maximize efficiency. "Any willing provider" statutes increase the number of health care providers in a network, thereby reducing each provider's total patient volume. This, in turn, reduces incentives for providers to accept reduced fees or to cooperate with utilization management mechanisms. Utilization management is the most significant method by which PPOs, HMOs and other managed care entities control health care costs and assess quality of care. Utilization management and the information derived from utilization management allow a PPO to credential and recredential providers, monitor overutilization and underutilization of health care services, and monitor and assess the quality of care provided in the network.

The limited number of participating providers in a PPO or other network setting helps contain health care costs, and plan participants realize cost savings through the use of the network providers. For instance, plan participants enrolled in a PPO plan may use the preferred (or network) providers or go outside the network to other physicians and hospitals for care. However, there are strong financial incentives designed to encourage patients to use the network providers. For example, the health care that participants

receive from preferred providers is often reimbursed at 90 to 100 percent of reasonable and customary charges. Health care obtained outside the network may be reimbursed at 80 percent or less, resulting in individuals paying more out of their own pockets.

Enforcement of Virginia's "any willing provider" statute would effectively eliminate the ability of *amici's* members to control health care costs by selectively contracting with efficient, yet highly skilled providers.

REASONS FOR GRANTING THE WRIT

The major question that petitioners have presented before this Court is whether Virginia's "any willing provider" statute, Virginia Code § 38.2-3401, regulates the "business of insurance" and therefore survives ERISA preemption. The Fourth Circuit held that the "any willing provider" statute was not preempted because it does regulate the "business of insurance." This holding effectively eliminates the ability of managed care organizations to deliver quality health care at a lower price. If provider networks become unlimited, the cost of doing business for managed care organizations will increase since it will either be impossible or considerably more expensive to impose appropriate cost controls. In addition, the likelihood of increased patient volume for individual health care providers will no longer exist. Thus, providers will no longer have a financial incentive to join PPOs at reduced fees.

In reaching its decision that the "any willing provider" statute regulates the "business of insurance," the Fourth Circuit improperly relied on *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985),

concluding that "any willing provider" laws regulate the "business of insurance." The Fourth Circuit should instead have applied the standard articulated in *Group Life & Health Ins. Co. v. Royal Drug Co., Inc.*, 440 U.S. 205 (1979), *cert. denied*, 469 U.S. 1160 (1985).

The Fourth Circuit's misapplication of the *Metropolitan Life* analysis is detrimental to *amici's* members, and accordingly, review by this Court is necessary.

A. The Fourth Circuit's decision will adversely affect *amici's* members' ability to contain escalating health care costs.

"Any willing provider" statutes, such as the Virginia statute at issue here, mandate that managed care organizations include in their networks any provider willing to meet the terms and conditions specified by the organization. These laws inhibit the effectiveness of alternate delivery systems, such as PPOs, by causing the network to become too large and costly to effectively administer. The inflated network will incur more costs and supply fewer patients to each participating health care provider; thus, diminishing or eliminating the system's overall cost savings.

One of the adverse consequences of "any willing provider" laws is the administrative difficulty of managing the larger networks that result. Increasing the number of provider applications per network requires significant staff time to process and properly verify the credentials of new applicants. New providers must be trained in network procedures. In addition, larger numbers of providers require additional monitoring by the PPO. A 1991 study by the Wyatt Company compared a simulated model of a larger network with

a baseline network. The baseline network was composed of approximately 25.5 percent of the individual health care providers and 44 percent of the hospitals in the network service area. The study concluded that if the number of network providers were increased to 40 percent of the available providers and 60 percent of the hospitals, there would be an 80.1 percent increase in the amount of administrative costs over the baseline network's administrative costs. *Report to Health Insurance Association of America: Cost Analysis of State Legislative Mandates on Six Managed Health Care Practices*, 14-26 (Wyatt Co. 1991) [hereinafter Wyatt Study].

Another detrimental aspect of "any willing provider" laws is the potential decrease in provider claims savings. By expanding the percentage of providers in the baseline model PPO, for example, the Wyatt Study found that providers are less likely to grant as big a discount as expected because each provider will have fewer patients directed his or her way. The provider will either deliver more services or give smaller discounts in order to maintain his or her current level of income (or, in the case of hospitals, their operating margins). The Wyatt Study concludes that the possible outcome of an "any willing provider" statute could be an 8.8 percent loss in claims savings as compared with the typical PPO. Wyatt Study, *supra*, at 20.

The conclusions of the Wyatt Study demonstrate that there is a point at which a PPO will be unable to demonstrate any value to the community if it is forced to accept more than a limited percentage of available providers. In fact, 20 percent or more of the hospitals and 40 percent or more of individual

providers will need to be excluded from the network in order to serve the community as a cost effective deliverer of health care services. *Id.* at 23.

It can be inferred from the Wyatt Study that selective contracting by a PPO or other managed care organization gives health care providers an incentive to join a managed care network. In the absence of "any willing provider" legislation, network providers will experience lower administrative costs and higher patient volumes, thereby fostering both competition and cost savings. Should Virginia's "any willing provider" statute survive preemption by ERISA, providers will no longer have incentives to become more efficient and more competitive in the services they offer. There will be too many health care providers in each network, resulting in too few patients per provider and the inability of providers to control costs through economies of scale.

The higher administrative costs of dealing with larger networks mandated by Virginia's "any willing provider" statute is likely to limit the availability of PPOs in the Commonwealth. Thus, a direct consequence of the Virginia law would be to limit consumers' ability to select alternative delivery systems for health care services. Indeed, the Federal Trade Commission ("FTC") has, on many occasions, concluded that "any willing provider" legislation inhibits competition among providers by limiting providers' incentive to compete in developing attractive or innovative proposals. *See, e.g.*, Letter from Thomas B. Carter, Director of the FTC, to John Smithee, Chairman of the Texas House Insurance Committee (May 18, 1993). The FTC has also issued opinions concerning the anti-competitive nature of "any willing prov-

ider" laws to officials in six other states: Massachusetts, Montana, New Hampshire, New Jersey, Pennsylvania, and South Carolina.[2]

Moreover, the use of preferred provider networks results in health care cost savings. For example, California was the first state to enact a selective contracting law enabling the formation of PPOs. Cal. Ins. Code § 10133 *et seq.* California leads the nation in the adoption of provider networks; its biggest success involves the use of hospital selective contracting. In fact, California hospitals have experienced a marked decrease in the rate at which their expenses have increased since the enabling legislation was passed. *See* Melnick, Zwanziger, and Verity-Guerra, *The Growth and Effects of Hospital Selective Contracting,* Health Care Manage Rev. (1989). Indeed, there has been phenomenal growth of PPOs throughout the country during the last decade. According to SMG Marketing Group, there are now 1036 PPOs operating or organized nationally, up from 978 in 1991. During

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[2] Other opinion letters include: Letter from Mary Lou Steptoe, Acting Director of the FTC, to William F. Cass, Vice-Chairman of the Massachusetts House Health Care Committee (June 15, 1993); Letter from Michael O. Wise, Acting Director of the FTC, to Joseph P. Mazurek, Montana Attorney General (February 4, 1993); Letter from Michael O. Wise, Acting Director of the FTC, to Paul J. Alfano, New Hampshire Senate Legal Counsel (March 17, 1992); Letter from Michael O. Wise, Acting Director of the FTC, to E. Scott Garrett, Chairman of the New Jersey Assembly Insurance Committee (March 29, 1993); Letter from Michael O. Wise, Acting Director of the FTC, to Roger A. Madigan, Pennsylvania State Senator (April 19, 1993); and Letter from Michael O. Wise, Acting Director of the FTC, to Thomas C. Alexander, Chairman of the South Carolina House Labor, Commerce and Industry Committee (May 10, 1993).

the same time period, the number of employees eligible to enroll in PPOs increased more than 50 percent, to almost 58 million lives. Since 1984, the growth in the number of PPOs has averaged 40 percent annually. *Directory of Operational PPOs*, SMG Marketing Group Inc. (9th ed. 1993).

Increasingly, employers are offering PPO plans to their employees. A recent survey conducted by Foster Higgins found that in 1992, 39 percent of employers offered a PPO program, up from 31 percent in 1991, even though this type of managed care has been generally available only since about 1983. *Health Care Benefits Survey 1992*, A. Foster Higgins & Co., Inc. (1992).

The consequences of allowing the decision of the Fourth Circuit to stand would be increased health care costs to Virginia consumers. This Court should not allow states to erect roadblocks to attempts by responsible ERISA plan sponsors to contain health care costs.

B. The Fourth Circuit failed to apply the appropriate precedent articulated by this Court in *Royal Drug* that the selection of network providers is not the "business of insurance."

Section 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, explicitly provides that, subject to certain exceptions, ERISA preempts all state laws that relate to employee welfare benefit plans. One of the exceptions embodied in ERISA is the insurance savings clause which saves from preemption any state law regulating insurance. 29 U.S.C. § 1144(b). This Court has adopted a two-step inquiry to determine whether

a law regulates insurance within the meaning of the savings clause. First, a court must make a "commonsense" determination as to whether the law regulates the "business of insurance." *Metropolitan Life*, 471 U.S. at 739 (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)). Second, the court must consider the three criteria which this Court has established to determine whether the "business of insurance" is exempt from federal antitrust regulation under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.; Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982).

The three criteria set forth in *Pireno* are: (1) whether the practice has the effect of transferring or spreading a policyholder's risk; (2) whether the laws regulate any practice that is an integral part of the policy relationship between the insurer and the insured; and (3) whether the laws are limited to entities within the insurance industry. *Union Labor Life*, 458 U.S. at 129.

In *Royal Drug*, a Blue Shield plan entered into a contract with pharmacists, whereby the pharmacists were to provide prescription drugs to the insurer's policyholders for a $2 charge, and the insurer would reimburse the pharmacists at cost. *Royal Drug*, 440 U.S. at 209. Applying the three *Pireno* criteria, this Court held that these arrangements did not involve the spreading or transfer of risk. The court reasoned that the risk involved was the insurer's obligation to reimburse drug costs to its insureds. The insurer had already assumed that risk in its insurance contracts. The arrangement with the pharmacists did not transfer or spread that risk but merely affected the insurer's cost of satisfying its obligations on a risk it

had already assumed. *Id.* at 213. This court, therefore, held that the arrangements were not the "business of insurance." *Id.* at 214.

The same reasoning applies here. The petitioner's PPO arrangements are contracts between Aetna and the health care professionals providing the services. They do not involve the underwriting of the insured's risk; all the risks assumed in the insurance policies are covered. The PPO arrangement merely establishes a network of providers which the insured may select when seeking treatment. As this court held in *Royal Drug*, contracts between a provider and an insurer or other entity do not constitute the "business of insurance" but rather the "business of insurance companies."[3] *Id.* at 217.

The Fourth Circuit distinguished the nature of the network in this case from that in *Royal Drug*, indicating that the provider network in *Royal Drug* was not a restricted network. *Stuart Circle*, 995 F.2d at 504. As pointed out in Aetna's petition, the very fact that pharmacies were unwilling to meet the terms of the Blue Shield contract made the network a restricted one. Brief for Petitioner at 20. Moreover, this Court made clear in *Royal Drug* that the open access of pharmacies to the pharmacy agreements was irrelevant to its decision. The result would be the same, the Court explained, if "an insurance company entered into a contract with a large retail drug chain whereby its policyholders could obtain drugs under

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[3] However, it is important to note that many PPOs are established and operated by entities that are not insurance companies; and therefore, such provider contracts would not even constitute the "business of insurance companies."

their policies only from stores operated by this chain." *Royal Drug*, 440 U.S. at 215. Such an arrangement, this Court concluded, is not the "business of insurance."[4] *Id.*

When the Fourth Circuit disregarded the holding in *Royal Drug*, it purported to apply the "common sense" approach to determine whether a law regulates the "business of insurance." The common sense approach requires the Court to ask whether the statute in question addresses matters typically within the purview of state insurance regulations, such as the solvency of an insurance company, the sale and advertising of insurance, and the content of the insurance policies. *Metropolitan Life*, 471 U.S. at 742. *Metropolitan Life* involved a Massachusetts mandated benefit law which required insurers to provide coverage for the treatment of mental illness. This Court held that the mandate regulated the "business of insurance" under ERISA because the law affected how and to what extent treatment was to be covered under an insurance policy. *Id.* The Virginia statute at issue in this case is distinguishable from the mental illness mandate in Metropolitan Life. Unlike the Massachusetts statute at issue there, the Virginia statute does not dictate coverages that insurers must include in their insurance or health care contracts. In fact, it involves a completely separate document from the insurance or health care contract and does not change the obligation of the insurer or managed care organization to provide benefits to its insureds or subscribers.

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[4] This issue is more fully discussed in Petitioner's Petition for Writ of Certiorari at page 21.

C. Proliferation of "any willing provider" legislation will erode the ability of insurers and other third party payors to create effective managed care networks.

Many states have passed anti-managed care legislation. For example, eight states have enacted "any willing provider" legislation which is substantially similar to the Virginia law.[5] In addition, nine states have enacted "any willing pharmacy" legislation, requiring pharmacy networks to accept any pharmacist willing to meet the terms and conditions of the network contract.[6] This proliferation of "any willing provider" legislation inhibits insurers and other third-party payors from developing effective managed care systems. Moreover, the increasing number of "any willing provider" laws enacted by the states compels companies which do business in multiple jurisdictions to comply with the requirements of varying laws, resulting in exactly the type of patchwork administra-

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[5] The eight states and the "any willing provider"statutes they have enacted are: Georgia, Ga. Code Ann. § 33-30-4.3 (1991); Illinois, 215 Ill. Comp. Stat. Ann. 5/370h (1993); Indiana, Ind. Code Ann. § 27-8-11-3 (Burns 1992); South Dakota, S.D. Codified Laws Ann. § 58-18-37 (1990); Utah, Utah Code Ann. § 31A-22-617 (1991); Washington, 1993 Wash. Laws Chapter 492; West Virginia, W.Va. Code § 33-25A-31 (1991); and Wyoming, Wyo. Stat. § 26-22-503 (1977).

[6] The nine states and the "any willing pharmacy" statutes they have enacted are: Alabama, Ala. Code § 27-45-3 (1988); Arkansas, Ark. Stat. Ann. § 23-79-143 (1991); Connecticut, Conn. Gen. Stat. § 38A-471 (1981); Florida, Fla. Stat. § 408.706(10) (1993); Idaho, Idaho Code § 41-1844 (1991); Louisiana, La. Rev. Stat. Ann. 22:1214(15) (West 1992); North Carolina, N.C. Gen. Stat. § 58-51-58 (1993); North Dakota, N.D. Cent. Code § 26.1-36-12.2 (1989); and Wisconsin, Wis. Stat. Ann. § 628.36 (1991 & Supp. 1992).

tive scheme which Congress intended to avoid in enacting ERISA. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). Finally, it should be noted that in enacting these "any willing provider" laws, states are attempting to regulate indirectly that which they clearly cannot regulate directly—employee welfare benefit plans.

CONCLUSION

For the foregoing reasons and for the additional reasons advanced in the Petition, the Court should grant the Petition for Writ of Certiorari and set the case for plenary review.

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No. 93-510

IN THE
Supreme Court of the United States
OCTOBER TERM, 1993

AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,
Petitioners,

v.

STUART CIRCLE HOSPITAL CORPORATION,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

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MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF *AMICUS CURIAE* OF THE ASSOCIATION OF PRIVATE PENSION AND WELFARE BENEFIT PLANS IN SUPPORT OF PETITIONERS

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MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE*

The Association of Private Pension and Welfare Benefit Plans ("APPWP") respectfully moves this Court, pursuant to Rule 36.3, for leave to file the attached brief *amicus curiae* in support of the petition for certiorari in this case. The consent of attorney for the petitioner has been obtained. The consent of attorney for the respondent was requested but refused.

The APPWP is a non-profit organization founded in 1967 to protect and foster the growth of this Nation's private employer-sponsored employee benefit plan system. The members of the APPWP include both small and large employer sponsors (including approximately 90 Fortune 500 companies) of employee benefit plans, as well as numerous plan support organizations, such as consulting and actuarial firms, investment firms, banks, insurers and

other professional benefit organizations. Collectively, its more than 400 members sponsor or administer plans covering more than 100 million plan participants. This broad-based membership provides the APPWP with substantial expertise and experience in the entire spectrum of issues relating to all types of benefit plans and the APPWP has filed *amicus curiae* briefs in numerous cases involving important issues for the employee benefit plan community.

This case raises an extraordinarily important ERISA preemption issue for employer plan sponsors as they struggle with the continued escalation in medical costs that has threatened the viability of the voluntary, private sector employee health plan system. Faced with this escalation, plan sponsors increasingly have turned to a variety of cost containment techniques in an effort to avoid benefit decreases or plan terminations. The preferred provider organization ("PPO"), under which plans can offer health care to plan participants at a reduced cost through a select panel of medical providers, has become an important weapon in this war on costs.

The decision below, if allowed to stand, can only serve to remove this innovative and effective cost-containment technique from a plan sponsor's already limited arsenal. The PPO, at bottom, is a contractual arrangement between the PPO and a select group of medical providers, under which the latter agree to provide services and/or goods to the PPO's subscribers on a discounted basis. By requiring PPOs to include "any willing" medical provider in the panel, the Virginia statute at issue effectively "guts" the PPO concept as a cost-saving device. If participation in the provider panel cannot be limited, medical providers will have no incentive to offer meaningful discounts to plans for one plain fact—plans will be in no position to offer providers the increased patient volume that is the *quid pro quo* for the provider discount. The net effect of this state effort to regulate the makeup of PPOs will be the demise of the preferred provider concept as a cost-containment tool, to the ultimate detriment of

plan sponsors, plans themselves, and their millions of participants.

This type of costly state interference into employee benefit plan affairs is precisely what Congress sought to eliminate in including in ERISA itself an express preemption provision that is "conspicuous for its breadth." *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990). Nor is the Virginia statute "saved" from preemption as a law "which regulates insurance" as the Fourth Circuit erroneously concluded. The state law at issue does *not* address the "business of insurance," but rather, the contractual relationship between medical care providers and the party establishing the PPO which, in this ~~case, h~~happens to be an insurance carrier. There is nothing "insurance-unique" about the creation of a PPO; indeed, numerous non-insurance companies have established PPO networks and marketed them to employee benefit plans. Moreover, in a remarkably analogous context, this Court has held that an insurance company's creation of a pharmacy network which provided prescription drugs to policy holders at discounted rates did not constitute the "business of insurance." *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). Accordingly, the mere fact that the state law in question addresses PPOs established by insurance companies in no way takes it outside the scope of ERISA's broad preemptive sweep.

The APPWP submits that the decision below is wrong and, unless reversed, threatens the delicate balance struck by Congress between protecting participants' rights and confining plan costs in fashioning a federal scheme to govern this area. Virginia's efforts, if successful, can only encourage other states to intrude upon employee benefit plan administration and design matters under the guise of state insurance regulation. Indeed, as noted in the petition for certiorari, numerous other states already have adopted similar laws which, in a variety of fashions, limit

the exclusion of medical providers from PPO networks.* Given the medical care crisis that already exists, it is imperative that this Court act now to protect the employee benefit plan community from this type of costly state interference.

The APPWP therefore urges this Court to grant the petition for certiorari in this case and to accept the attached brief to assist the Court in its resolution of this matter.

Respectfully submitted,

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* *See* Petition for Certiorari at 10 n.2. *See* also BlueCross Blue Shield Association, *State Barriers to Managed Care: Results of a National Survey of Blue Cross and Blue Shield Plans* (2d ed. 1992), at 6-8.

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BRIEF *AMICUS CURIAE* OF THE ASSOCIATION OF PRIVATE PENSION AND WELFARE BENEFIT PLANS IN SUPPORT OF PETITIONERS

INTEREST OF *AMICUS CURIAE*

The interest of the *amicus curiae* is set forth in the motion accompanying this brief.

SUMMARY OF ARGUMENT

This case raises an extraordinarily important ERISA preemption question for employer plan sponsors already struggling with the continued escalation in health care costs. It is no secret that the continued rise in health care costs has placed enormous pressures on the Nation's private employee benefit plan system. Indeed, a recent General Accounting Office study indicates that in 1990

alone, American businesses spent 186 billion dollars in providing medical benefits to their employees.[1] The enormous cost of medical care threatens not only the continued existence of many employer-sponsored health plans, but also the economic competitiveness of many plan sponsors themselves.

Faced with expenditures of this magnitude, plan sponsors increasingly have turned to innovative cost-containment mechanisms in an effort to avoid massive benefit cuts or, in some cases, the termination of medical coverage entirely. The decision below, however, threatens the continued vitality of a major cost-saving option utilized by plan sponsors and plans today—the preferred provider organization ("PPO").

The PPO enables plans to offer participants access to a select group of medical providers who have agreed to provide their services on a discounted basis. The PPO's ability to contain or reduce a plan's medical expenditures is integrally tied to the PPO's ability to limit the number of preferred medical providers available to plan participants under the program. Only if the number of preferred providers is limited can a PPO offer the increased patient volume necessary to secure meaningful discounts from the providers. By upholding a state law requiring insurance company-sponsored PPOs to extend "preferred" status to "any willing" medical provider, the decision below effectively strips these PPOs of the ability to offer this essential *quid pro quo*. The inevitable result of this holding will be the demise of the PPO as a cost-saving mechanism, at least where sponsored by insurance companies, to the ultimate detriment of plan sponsors, plans themselves, and their participants.

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[1] U.S. General Accounting Office, *Employer-Based Health Insurance: High Costs, Wide Variation Threaten System* (GAO/HRD-92-125) (1992) (hereinafter "GAO Study"), at 3.

Not only is the decision below bad policy given the current crisis in medical care costs, it is bad law. While Congress' primary goal in enacting ERISA was the protection of participants' interests in their plans, it also recognized the voluntary nature of the employee benefit plan system. Accordingly, in crafting its comprehensive federal regulatory scheme for this area, Congress took steps to insure that employers would not respond "by decreasing benefits under existing plans or slowing the rate of formation of new plans." H.R. Rep. No. 807, 93d Cong., 2d Sess. 15 (1974). Among these steps was the elimination of the conflicting and costly maze of state regulation that had burdened plans in the past through an express preemption clause that this Court repeatedly has recognized as "conspicuous for its breadth."

The Fourth Circuit's conclusion that the state law in question is "saved" from ERISA preemption as a law "regulating insurance" is plainly wrong. The creation of a PPO simply is not transformed into the "business of insurance" whenever an insurance carrier engages in that activity. There is nothing "insurance unique" about the creation of a PPO network of providers; numerous non-insurers have created such networks and marketed them to employee benefit plans. Moreover, the inclusion of a particular provider in the PPO network in no way involves the relationship between the insurer and an insured; rather, it involves the contractual relationship between the provider and the PPO and the terms upon which the provider will make its services available. Not surprisingly then, in a closely analogous context, this Court has held that an insurance company's creation of a network of pharmacies which provided prescription drugs to insureds on a discounted basis did *not* constitute the business of insurance. *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). This Court's analysis in *Royal Drug* is controlling here and requires reversal of the decision below.

In sum, the delicate balance struck by Congress in ERISA between protecting participant rights and confining plan costs so as not to undermine the private employee benefit plan system requires preemption of the Virginia law here involved. This Court therefore should grant the petition and reverse the decision below.

ARGUMENT

1. The continued escalation in health care costs and the enormous burdens it has placed both on American businesses and the Nation's private employee benefit plan system are matters of public record. A recent General Accounting Office study indicates that in 1990 alone, American businesses spent approximately 186 billion dollars in providing health care benefits to their employees. GAO Study at 3. This same study pointed out the devastating impact these costs have on many American businesses:

> Rapidly increasing business outlays for group health insurance are a serious problem for all firms, but some firms have experienced severe hardships as their costs have escalated to levels that threaten the competitiveness of the firm. Firms in declining industries with aging work forces are faced with health insurance premiums that exacerbate their competitive problems. Such firms not only have to deal with the general rise in health care costs, but also are hit by further increases which reflect the poor health experience of their aging work force. Small firms are even more vulnerable since poor health experiences of one or two workers can threaten their capacity to obtain affordable health insurance coverage.

Id. at 12.

Faced with these dramatic costs, employer plan sponsors have few alternatives. Some firms, particularly small firms, have had little choice but to reduce benefits sig-

nificantly or eliminate coverage for their employees entirely. *Id.* at 12 n.16. Indeed, in 1990, nearly 50% of the Nation's uninsured were employed on either a full or part-time basis, while approximately an additional 33% of the uninsured were non-working dependents of such employees. *Id.* at 23. Such actions only heighten the problems faced by those employers who have continued to provide medical benefits to their employees since generally "health costs associated with uninsured or underinsured small firm employees are passed on to larger firms." *Id.* at 12 n.16.

Other firms have responded to the crisis through a variety of innovative cost-containment and savings measures largely designed to permit them to continue providing meaningful coverage to their employees. Managed care programs, such as PPOs and Health Maintenance Organizations ("HMOs") which impose limitations on a participant's choice of provider, have proven to be popular and cost-effective alternatives for plan sponsors in their efforts to combat medical costs. A recent study indicates that in 1991, a majority of Americans with health coverage were enrolled in such managed care-type programs.[2] Moreover, during 1991 alone, PPOs and similar point of service plans increased their market share by over 40%.[3]

A PPO is able to reduce plan costs by extending plan participants access to a select panel or network of medical providers who have agreed to provide medical services on a discounted or other non-traditional fee-for-service basis. A PPO's ability to offer such savings to plans and plan sponsors in large part is dependent on the PPO's ability

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[2] KPMG Peat Marwick, *Health Benefits in 1992, in Benefits Spectrum* (Oct. 1992), at 2.

[3] *Id.* (indicating that the market share of such plans increased from 24% to 34% in 1991).

to limit the number of providers who are "preferred" or included within the network. This is because the PPO can offer providers the increased patient volume that is the essential *quid pro quo* for the negotiated discount arrangements only if the number of providers is limited. "Any willing provider" statutes such as that upheld by the court below effectively "gut" the preferred provider concept by eliminating the PPO's bargaining power in this key area. Not surprisingly then, a recent study estimated that such laws would reduce a plan's savings on benefit claims anywhere from 8% to over 14%.[4]

Nor are the lost savings limited to benefit claims. Such legislation also increases the PPO's costs both in establishing and administering the provider network. For example, if it must deal with all providers, rather than a select few, the PPO will incur increased expenses in credentialing providers, negotiating, executing, and administering provider agreements, and monitoring provider performance.[5] The same study which found a reduction in benefit savings estimated that "any willing provider" legislation increases a PPO's administrative costs anywhere from 34% to 52%.[6] These additional costs obviously would be passed on to plans, thereby further undermining the PPO's effectiveness as a cost-containment measure.

The net losers if such state legislation is upheld obviously will be plan sponsors, their plans, and ultimately plan participants themselves, all of whom will be deprived

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[4] The Wyatt Co., *Report to Health Insurance Association of America: Cost Analysis of State Legislative Mandates on Six Managed Health Care Practices* (1991), at 19-20 (hereinafter "Wyatt Study"). *See also* BlueCross BlueShield Association, *State Barriers to Managed Care: Results of a National Survey of Blue Cross and Blue Shield Plans* (2d ed. 1992), at 5 (hereinafter "BlueCross Study").

[5] BlueCross Study at 6.

[6] Wyatt Study at 15-16.

of a significant cost-saving opportunity at the very time that medical cost escalation has threatened the viability of the voluntary, private sector employee benefit plan system. Nor is this potential harm mitigated by the fact that Virginia statute addresses only insurance company-sponsored PPOs. If the creation of a PPO is viewed as the "business of insurance" subject to permissible state regulation, state efforts to regulate the makeup of PPOs established by non-insurance companies can be anticipated.[7] Moreover, even if such laws are limited to insurance company-sponsored PPOs, the elimination of insurers from the PPO market will have a negative impact on the availability of PPO-type arrangements to many plans, and small plans in particular. Unlike insurance carriers, many plans simply do not possess "enough negotiating power in geographic health care markets" to "obtain[] discounted fees with providers."[8] Thus, if allowed to stand, the decision will greatly undermine, if not eliminate, the PPO as a meaningful cost-saving alternative.

2. The decision below is consistent with ERISA's purposes and incompatible with its broad preemption of state law. While Congress' "primary goal" in enacting ERISA was the protection of the interests of plan participants, it also was keenly aware of the voluntary nature of our employee benefit plan system and "the public interest in encouraging the formation of employee benefit plans."

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[7] For example, in *General Motors Corp. v. California State Bd. of Equalization*, 815 F.2d 1305 (9th Cir. 1987), *cert. denied*, 485 U.S. 941 (1988), a state insurance "premium tax" calculated by reference to benefits paid by plans which had purchased "excess-risk" insurance and passed on by insurers to such plans was upheld against preemption challenge as a law regulating insurance. This ruling undoubtedly encouraged state efforts to impose a similar tax on plan administrators. *See E-Systems, Inc. v. Pogue*, 929 F.2d 1100 (5th Cir.), *cert. denied*, 112 S. Ct. 585 (1991) (finding such law preempted by ERISA).

[8] GAO Study at 24.

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987). Indeed, ERISA's legislative history makes clear that Congress was concerned not to burden plans so heavily by ERISA's requirements that "employers respond . . . by decreasing benefits under existing plans or slowing the rate of formation of new plans." H.R. Rep. No. 807 at 15.

Not only did Congress seek to minimize the regulatory burdens imposed by ERISA itself, it also relieved plan sponsors and plans from the costly, conflicting and inefficient maze of state regulation that had plagued them in the past. It did so through the inclusion of an express preemption provision—ERISA § 514(a), 29 U.S.C. § 1144(a)—which is "conspicuous for its breadth" and "establishes as an area of exclusive federal concern the subject of every state law that 'relate[s] to' an employee benefit plan governed by ERISA." *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990). The reason for its inclusion is clear:

> ERISA's pre-emption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patchwork scheme of [state] regulation would introduce considerable inefficiencies in benefit program operation, *which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them.*

Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 11 (1987) (emphasis added).

The court below correctly determined that the Virginia statute here involved "relates to" employee benefit plans, and thus falls squarely within the scope of ERISA's preemption provision. Indeed, this relationship is beyond dispute since the primary market for PPOs is employee benefit plans and any state regulation of the PPO's makeup

directly impacts a plan's benefit structure, administration and costs. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (state mandated benefit law requiring inclusion of minimum mental health coverage in group health insurance policies "relates to" employee benefit plans within meaning of ERISA's preemption provisions).

However, the court's ultimate conclusion that this statute was "saved" from preemption under ERISA § 514 (b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), as a law "regulating insurance" constitutes plain and dangerous error. This court's prior teachings demonstrate that this savings clause was not intended to allow state regulation of all aspects of an insurance company's plan-related activities. *See Pilot Life Ins. Co. v. Dedeaux, supra; Metropolitan Life Ins. Co. v. Massachusetts, supra.* Rather, like the similarly worded McCarran-Ferguson Act, the savings clause "appears to have been designed to preserve the . . . reservation of the *business of insurance* to the States." *Metropolitan Life*, 471 U.S. at 744 n.21 (emphasis added). Thus, only state laws which regulate the "business of insurance," as opposed to the business of insurance companies, properly can fall within its ambit. And, indeed, the lower courts have held that an insurance company's plan-related activities are outside the saving clause's scope where they do not constitute the "business of insurance." *See, e.g., Powell v. Chesapeake & Potomac Tel. Co.*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986) (insurance company's provision of administrative services to plan is not the business of insurance); *Insurance Bd. v. Muir*, 819 F.2d 408 (3d Cir. 1987) (to same effect as *Powell*).

The decision below blurs and confuses this basic distinction between the "business of insurance" which is within the savings clause, and the "business of insurance companies," which is without. As a threshold matter, the

business activity here at issue does not even qualify as the "business of insurance companies." While insurance companies have become increasingly active in establishing PPO networks and marketing them to plans on both an insured and self-funded basis, there is nothing insurance company "unique" or "specific" about the creation and administration of a PPO network of medical providers. Many PPOs in operation today are sponsored, developed and promoted by groups of medical providers themselves or by HMOs.[9] In addition to this "provider sponsored plan" model, others are developed by third party entrepreneurs who are neither providers or insurance carriers.[10] These "broker model" plans incur the expenses associated with establishing a network of providers, *e.g.*, soliciting and negotiating contracts with multiple providers and administering the program, and "sell access to these networks to insurance companies and self insured employers."[11] Thus, the creation and administration of a PPO is not even the "business of insurance companies," but rather, a business activity engaged in by insurance companies and many other non-insurers.

More importantly, the activity regulated by the Virginia statute does not constitute the "business of insurance" under any proper definition of that term. The precise activity regulated by the Virginia statute—a PPO's inclusion or exclusion of medical providers—simply does not involve the "relationship between insurer and insured" which this Court has recognized repeatedly as the "focus" of the business of insurance. *E.g.*, *SEC v. National Sec., Inc.*, 393 U.S. 453, 460 (1969). Nor does it involve the underwriting or spreading of a policyholder's

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[9] National Health Lawyers Association, *The Insider's Guide to Managed Care: A Legal and Operational Roadmap* (1990), at 20-21, 53.

[10] *Id.*

[11] *Id.* at 21.

risk which is an "indispensable characte[illegible] of insurance." *Royal Drug*, 440 U.S. at 212.

Rather, the statute is directed at the contractual relationship between the PPO and medical providers and the terms upon which those providers will make their services available under the PPO program. While this contractual relationship impacts an insurer's costs in meeting its obligations under any contract of insurance it might offer allowing access to its PPO, the PPO-provider relationship is entirely separate and distinct from that between the insurer and the insured and any underlying policy of insurance. Indeed, the best evidence that the contractual relationship between a PPO and its medical providers does not constitue the "business of insurance" is that such relationship is part and parcel of *every* PPO, including those established by *non*-insurers and those which provide access to plans on a *non*-insured, fee-for-service basis.[12] If this relationship is not the "business of insurance" in these latter situations—and it is not—there is no reasoned basis for concluding that it becomes such whenever a PPO is sponsored by an insurance company and made available to employee benefit plans on an insured basis.

Not surprisingly then, in a remarkably analogous context, this Court already has concluded that an insurance carrier's contractual relationship with a provider of goods and services to its policyholders is not the "business of insurance." In *Group Life & Health Ins. Co. v. Royal Drug Co., supra*, an insurance carrier entered into agreements with pharmacies, under which the pharmacies agreed to provide prescription drugs to policyholders on a discounted basis. In holding that this insurer-created pharmacy "network" did not constitute the business of

[12] Of course, even insurance company-sponsored PPOs, including the petitioner in this case, offer their services to plans on a non-insured basis, *i.e.*, self-funded plans pay a fee for access to the network. See District Court Op., Petition at 15a.

insurance, the Court emphasized two facts. First, the participating pharmacy agreements were "*not* 'between insurer and insured' ", but rather, were "separate contractual arrangements between [the insurer] and pharmacies engaged in the sale and distribution of goods and services other than insurance." 440 U.S. at 216. Second, the agreements did not involve the underwriting of risk, but the terms upon which the insurer would pay for goods and services in meeting its contractual commitments to policyholders. As the Court explained:

> The fallacy of petitioners' position is that they confuse the obligations of Blue Shield under its insurance policies, which insure against the risk that policyholders will be unable to pay for prescription drugs during the period of coverage, and the agreements between Blue Shield and the participating pharmacies, which serve only to minimize the costs Blue Shield incurs in fulfilling its underwriting obligations.

Id. at 213. This same analysis applies here and requires reversal of the decision below.[13]

In short, Virginia's attempt to impose an "any willing provider" requirement on insurance company-sponsored

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[13] Nor can the *Royal Drug* decision be distinguished on the ground suggested by the court below—that participation in the pharmacy network is available to "any pharmacy which agreed to the insurance company's terms." Fourth Circuit Op., Petition at 12a. This feature played *no* part in this Court's conclusion that the activity there involved did not constitute the business of insurance. Indeed, this Court made clear that the insurer's contractual relationship with pharmacies would not constitute the business of insurance even if it had chosen to deal with a single vendor through the following example:

> Suppose, for example, that an insurance company entered into a contract with a large retail drug chain whereby its policyholders could obtain drugs under their policies only from stores operated by this chain.

Royal Drug, 440 U.S. at 215. Thus, an insurer's ability to exclude providers from a PPO is totally irrelevant to the "business of insurance" equation.

PPOs does not regulate the "business of insurance," and thus falls outside the scope of the insurance savings clause. This Court therefore should give full effect to ERISA's broad preemption provision to relieve plans and plan sponsors from this form of costly and inefficient state interference. Moreover, this Court should do so now so as to assure the employee benefit plan community that it will not be deprived of this increasingly important weapon in combating the current crisis in medical care costs.

CONCLUSION

For the reasons stated above, this Court should grant the petition for certiorari and reverse the decision below.

Respectfully submitted,

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No. 93-510

IN THE
Supreme Court of the United States
OCTOBER TERM, 1993

AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,
Petitioners,

v.

STUART CIRCLE HOSPITAL CORPORATION,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE AND BRIEF AMICUS CURIAE FOR THE AMERICAN COUNCIL OF LIFE INSURANCE IN SUPPORT OF THE PETITION

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MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE FOR THE AMERICAN COUNCIL OF LIFE INSURANCE IN SUPPORT OF THE PETITION

The American Council of Life Insurance ("ACLI") hereby moves, pursuant to Rule 37.2 of the Rules of this Court, for leave to file the attached brief as amicus curiae. Consent to the filing of this brief has been obtained from counsel for the petitioners, Aetna Life Insurance Company and Aetna Health Management. Counsel for the respondent, Stuart Circle Hospital Corporation, has refused consent.

The ACLI is the largest life insurance trade association in the United States, representing the interests of 616 member life insurance companies. The ACLI's members currently hold 95 percent of the life insurance in force in

legal reserve life insurance companies in the United States. Most of its members also provide health insurance.

The insurance industry plays a critical role in providing welfare benefits to members of the nation's workforce through benefit plans governed by the Employee Retirement Income Security Act of 1974, *as amended*, 29 U.S.C. §§ 1001-1461 ("ERISA"). As of 1979, insurance companies—including many members of the ACLI—funded through group policies approximately 99 percent of the benefit plans in the United States that covered fewer than 100 participants. *See* "Employee Welfare Benefit Plans and Plan Sponsors in the Private Non-farm Sector in the United States, 1978-79," Health and Population Study Center, Battelle Human Affairs Research Centers, Vol. IV (1980), at 43-45. Approximately 92 percent of the plans in this country covering greater than 100 participants were also funded in this way. *Id.* Many members of the ACLI offer or administer preferred provider organizations ("PPOs") that provide significant cost savings to employee welfare benefit plans subject to ERISA.

Because of its nationwide constituency, the ACLI is peculiarly able to present to this Court the views of the life and health insurance industries concerning the issue presented in this case: whether ERISA preempts a state law that mandates that any health care providers "willing" to meet the terms of an insurer-offered or insurer-administered PPO used by an employee benefit plan to deliver health care services must be included in the PPO. Those views are particularly important where, as here, resolution of this case requires interpretation of ERISA's "insurance saving clause" and turns in part on the meaning of "regulating the business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015. They are also important because, if the decision below stands, it will greatly increase the costs to employers of providing health care benefits to their employees and their dependents by, in effect, eliminating the PPO as an innovative and

extremely popular means of providing cost-efficient health care in states with "any willing provider" laws.

In other ERISA cases, the ACLI has submitted amicus briefs to this Court. *See, e.g., Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). For these reasons, the motion for leave to file the attached brief amicus curiae in support of the Petition should be granted.

Respectfully submitted,

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QUESTION PRESENTED

Whether a state law that mandates only the health care providers to be included in a preferred provider organization used by an employee benefit plan to deliver health care services, rather than restricts the services that such providers must provide participants in such plans, is preempted under the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

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BRIEF AMICUS CURIAE FOR THE AMERICAN COUNCIL OF LIFE INSURANCE IN SUPPORT OF THE PETITION

This brief is filed on behalf of the American Council of Life Insurance ("ACLI"), as amicus curiae, in support of the petition for certiorari.[1]

INTEREST OF THE AMICUS

As explained in more detail in the accompanying Motion, the ACLI is the largest life insurance trade association in the United States, representing the interests of

[1] Consent from counsel for Aetna Life Insurance Company and Aetna Health Management has been filed with the Clerk of this Court. Because counsel for Stuart Circle Hospital Corporation refused to give consent, this brief is accompanied by a motion for leave to file this amicus brief.

616 member life insurance companies. The ACLI's members currently hold 95 percent of the life insurance in force in legal reserve life insurance companies in the United States. Its members also play a critical role in providing welfare benefits to members of the nation's workforce by insuring and or administering benefit plans governed by the Employee Retirement Income Security Act of 1974, *as amended*, 29 U.S.C. §§ 1001-1461 ("ERISA").

The legal and practical consequences of the Fourth Circuit's decision below are matters of grave concern to the members of the ACLI. That decision—that ERISA does not preempt a state law that mandates the inclusion of "any willing provider" in a preferred provider organization ("PPO") offered or administered by an insurance company—greatly increases the costs to employers of providing health care benefits to their employees and their dependents. In effect, it threatens to eliminate an innovative and extremely popular means of providing cost-efficient health care. Because of this impact, the ACLI seeks to file this brief to provide the Court with the unique perspective of its broad-based constituency on this important federal question.

STATUTES INVOLVED

1. Section 514(a) of ERISA provides, in pertinent part, that:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

29 U.S.C. § 1144(a).

2. Section 514(b) of ERISA provides, in pertinent part, that:

> (2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.
>
> [2](B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title . . . nor any trust established under such plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies, [or] insurance contracts . . . .

29 U.S.C. § 1144(b).

3. Section 514(c) of ERISA provides, in pertinent part, that:

> (1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State . . . .
>
> (2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

29 U.S.C. § 1144(c).

4. Section 2 of the McCarran-Ferguson Act provides, in pertinent part, that:

> (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by a State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the

> business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

15 U.S.C. § 1012.

5. Section 38.2-3407 of the Virginia Code provides, in relevant part, that:

> A. One or more insurers may offer or administer a health benefit program under which the insurer or insurers may offer preferred provider policies or contracts that limit the numbers and types of providers of health care services eligible for payment as preferred providers.
>
> B. Any such insurer shall establish terms and conditions that shall be met by a hospital, physician or type of provider listed in § 38.2-3408 in order to qualify for payment as a preferred provider under the policies or contracts. These terms and conditions shall not discriminate unreasonably against or among such health care providers. No hospital, physician or type of provider listed in § 38.2-3408 willing to meet the terms and conditions offered to it or him shall be excluded. Neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with providers or based on market conditions, or price differences among providers in different geographical areas, shall be deemed unreasonable discrimination. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.

Virginia Code § 38.2-3407.

STATEMENT

Like a number of other states, Virginia has enacted, as part of its state insurance code, what is commonly referred to as an "any willing provider" statute. This "any willing provider" law requires a PPO, offered or administered by an insurer, to include in its organization any health care provider willing to meet the terms and conditions of the organization. As enacted, the mandate embodied in Virginia Code § 38.2-3407 is not limited to situations where an insurance company insures, through the issuance of insurance to the subscriber plan, the payment of the services offered by the PPO. It also applies when the insurance company does no more than administer a PPO for the benefit of self-insured employee benefit plans.

Aetna Life Insurance Company ("Aetna") both administers and insures employee benefit plans providing benefits in Virginia. Pet. 4. Aetna Health Management ("Aetna Health") maintains and manages the PPO that Aetna established to serve the Richmond, Virginia area. *Id.* Both insured and self-insured employee benefit plans subscribe to Aetna's Richmond PPO; for those plans that are self-insured, Aetna merely provides administrative services. *Id.*

Stuart Circle Hospital Corporation ("Stuart Circle") owns and operates a hospital in Richmond. Pet. 4. In structuring and establishing its Richmond PPO, Aetna did not include Stuart Circle as a provider. *Id.* Stuart Circle responded by suing Aetna and Aetna Health in Virginia state court, alleging a violation of Virginia Code § 38.2-3407. *Id.* Aetna and Aetna Health removed the case, on diversity grounds, to the United States District Court for the Eastern District of Virginia. *Id.*

The Proceedings Below

The district court granted Aetna's motion for summary judgment, holding that ERISA preempted Section 38.2-

3407 of the Virginia Code. Pet. App. 14a-32a. The court concluded that the Virginia law "relates to" employee benefit plans, as contemplated in the preemption provisions of ERISA § 514(a) (*id.* at 18a-24a), and is not "saved" from preemption as a law that "regulate[s] insurance", as contemplated in ERISA § 514(b)(2)(A). *Id.* at 24a-32a. In holding that the Virginia law is not "saved" from preemption, the district court relied on the criteria used in determining whether a state law "regulates insurance" under the McCarran-Ferguson Act. *Id.*

Specifically, the district court relied on this Court's decision in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), that a service arrangement between an insurance company and a group of pharmacies, which restricted the pharmacies available to the insured participants of employee benefit plans, was not an arrangement that involved the "business of insurance." By analogy, the district court held that state-mandated inclusions of willing providers into PPOs do not involve the type of transfer of risk between an insurer and an insured that is essential to the "business of insurance." Pet. App. 27a-28a. Rather, according to the court, a PPO is merely a contractual relationship among health care providers permitting an insurance company, through its management or administration of the PPO, to aid in providing cost-efficient health care to the participants of subscribing employee benefit plans. *Id.*

On appeal, the Fourth Circuit reversed, holding that the Virginia statute is not preempted because that law regulates the "business of insurance" as contemplated in ERISA's "savings" clause. Pet. App. 3a-13a. The Fourth Circuit based its holding on two grounds. First, it concluded that the Virginia "any willing provider" law regulates the "business of insurance" because it indirectly regulates the relationship between the insurer and the insured, as well as the type of policy that may be issued. *Id.* at 9a. Second, it concluded that the Virginia law meets all three prongs of the test for the "business of

insurance" traditionally used in the context of the McCarran-Ferguson Act. *Id.* at 9a-11a. In the court's view, the law (1) transferred the risk that the service will not be provided by the health provider of the policyholder's choice, (2) affected an integral part of the policy relationship between the insured and the insurer, and (3) applied solely to entities within the insurance industry. *Id.*

REASONS FOR GRANTING THE WRIT

I. THE COURT BELOW DECIDED AN IMPORTANT ISSUE OF FEDERAL LAW IN A MANNER INCONSISTENT WITH THE DECISIONS OF THIS COURT.

Section 514(b)(2)(A) of ERISA saves from preemption any state law that "regulates insurance." 29 U.S.C. § 1144(b)(2)(A). In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985), this Court stated that the "business of insurance" for purposes of ERISA's "savings" clause is coextensive with those activities that are reserved to state regulation under the McCarran-Ferguson Act. Thus, this Court has applied the criteria for evaluating the "business of insurance" under the McCarran-Ferguson Act in deciding the applicability of ERISA's "savings" clause to state laws. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

In so doing, this Court has used the three-prong test articulated in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982), and *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), to define the scope of the phrase "any law of any State which regulates insurance" in ERISA's "savings" clause. That test, applied to ERISA in *Metropolitan Life*, means that a state law will be deemed to "regulate insurance" if it (1) effects the transfer or spreading of risk between the insurer and the policyholder; (2) is limited to entities within the insurance industry; and (3) affects an integral part of the insured and insurer relationship. *Pireno*, 458

U.S. at 129; *Royal Drug*, 440 U.S. at 214-224; *Metropolitan Life*, 471 U.S. at 743.

By holding that the Virginia "any willing provider" law is a law regulating the "business of insurance" under this test—thus saving it from ERISA's broad preemptive reach—the Fourth Circuit both misconstrued and misapplied the well-established three-prong test of *Pireno* and *Royal Drug*. In the process, it has threatened widespread disruption of a widely-accepted method of providing cost-efficient health care—at a time when health care costs are spiraling—that only this Court can promptly avert.[2]

A. The Virginia Law Does Not Effectuate The Transfer Of Risk. The decision below that Virginia's "any willing provider" law effectuates the transfer of risk plainly misapplies this Court's well-settled insurance law principles: the Virginia law does not involve the true "underwriting" of risks—"the one earmark of insurance" (*SEC v. Variable Annuity Life Ins. Co.*, 359 U.S. 65, 73 (1959))—much less the transfer of risk from an insured to the insurer that defines the contract of insurance.

Insurance companies that offer or administer PPOs are not engaged in the "underwriting" of insurance or the spreading of risk through a contract with one or more insured individuals or groups. *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. at 211 ("The primary elements of an insurance contract are the spreading

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[2] In *United States Dept. of Treasury v. Fabe*, a non-ERISA case, this Court recently reiterated the validity of the three-prong test of *Pireno* and *Royal Drug* in determining what constitutes the "business of insurance" for purposes of the McCarran-Ferguson Act. 113 S.Ct. 2202 (1993). Moreover, most circuits have expressly adopted the three-prong test in determining the scope of ERISA's savings clause. *See, e.g., Gahn v. Allstate Life Ins. Co.*, 926 F.2d 1449, 1453 (5th Cir. 1991); *DeBruyne v. Equitable Life*, 920 F.2d 457, 469 (7th Cir. 1990); *Howard v. Gleason Corp.*, 901 F.2d 1154, 1158 (2d Cir. 1990); *Anschultz v. Connecticut General Life Ins. Co.*, 850 F.2d 1467, 1468 (11th Cir. 1988); *The Insurance Board Under the Social Ins. Plan of Bethlehem Steel Corp.*, 819 F.2d 408, 411 (3d Cir. 1987).

and underwriting of a policyholder's risk. 'It is characteristic of insurance that a number of risks are accepted, some of which involve losses, and that such losses are spread over all the risks so as to enable the insurer to accept each risk at a slight fraction of the possible liability upon it' "). Rather, such insurance companies are merely providing a service to employers sponsoring employee benefit plans by aiding those sponsors in implementing their particular health plans in the most cost-efficient manner.

The absence of a risk transfer, in the insurance sense, is clearly evident from the basic structure of a PPO. A PPO is nothing more than a mechanism for an employer to provide health care benefits to its employees, through an employee welfare benefit plan, at a reduced cost. The creator of a PPO enters into contracts with a limited number of health care providers, *i.e.*, "preferred providers," for the purpose of providing health care services to employee benefit plans. Cost savings result from the chosen health care providers' willingness to provide their services at substantial discounts due to various reasons, including the assured increase in patient volume that the PPO network of subscribers can guarantee.

Generally, this increase in patient volume is achieved through financial incentives given to participating plan participants. For example, an employee benefit plan that subscribes to the PPO may offer to pay participants a greater percentage of any cost of treatment rendered to them by preferred providers. The resulting increase in patient volume, in turn, yields a lower per patient cost to the preferred providers by spreading the fixed cost of the PPO. This enables the providers to lower the charges per incidence of service.

Thus, a PPO is merely a contractual relationship between the PPO creator, or administrator, and the various preferred health care providers. The PPO contract does not specify what health care services will be covered by any particular subscribing employee benefit plan; it does not, by its terms, provide insurance coverage to any sub-

scribing plan or require any plan to be insured in order to subscribe. Indeed, in many instances, the PPO creator or administrator may not even be an insurance company. Thus, whether a subscribing plan is fully-insured, partially-insured, or self-insured is a separate contractual matter totally outside the PPO contract. The PPO contract does nothing more than specify the discounted fees for which the various preferred providers within its network will provide their services to subscribers.

To the extent that providing services through a PPO network has a cost impact, this impact redounds to the plan and its participants—not to the insurer—in a manner that would constitute the "underwriting" of risk. For example, an insurer/administrator of a PPO that is also providing the insurance coverage for a subscriber plan can easily cap its costs based on a predetermined benefit-by-benefit payment schedule. Therefore, to the extent that more costly providers are added to the PPO network, the insurer *qua* insurer would need to pay no more than the scheduled amount, while either the plan sponsor or the participant would pay the monetary difference for the particular provision of service. Thus, in this instance, insofar as any shifting of cost occurs, it would consist of the mere shifting of cost for providing a defined list of services between the plan and its participants and the PPO itself. Such a risk shifting would, if anything, indicate that insurer status should apply either directly or indirectly to the plan. Clearly, however, the "deemer" clause would preclude any attempt to apply state insurance law directly to the plan or its participants or sponsor.[3]

Even where the employee benefit plan is fully insured through an insurance contract that specifically limits pay-

[3] Section 514(b)(2)(B) of ERISA is known as the "deemer" clause because it states, in effect, that no employee benefit plan may be deemed to be an insurance company or other insurer for purposes of any law of any state purporting to regulate insurance companies or contracts.

ments of benefits to services rendered by members of a particular PPO, that contractual restriction does not result in an underwriting of risk in the insurance sense. This is due to the fact that such a policy does not in any way restrict the type of illness or injury covered, *i.e.*, the type of benefit provided. Rather, such a provision restricts only *who* will provide the services. Such a restriction does not affect the risk that any individual participant will or will not be reimbursed for the treatment of any particular illness or injury. And it is this risk—that of being reimbursed for the treatment of any particular illness or injury—that is the generally-accepted relevant risk for purposes of determining insurance status. *See, e.g., United States Dept. of Treasury v. Fabe*, 113 U.S. 2202, 2209 (1993); *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981).

B. The Law Affects Entities Other Than Insurance Companies. The second prong of the three-prong test for determining whether a particular law regulates an activity involving the "business of insurance" involves determining whether the law applies *solely* to entities in the insurance industry. There is no legal or practical reason why the business of composing PPO networks is, or indeed should be, limited to insurance companies. In fact, many PPOs are created and administered by groups of medical service providers themselves—without any involvement of an insurance company. In addition, many benefit consulting groups structure such networks of health care service providers for their plan sponsor clients. In neither of these two fact patterns does the entity creating the PPO network assume any type of risk relating to benefits being provided to the subscriber plans. Therefore, it is plain that the function of creating or administering a PPO network, in and of itself, has nothing to do with an assumption of risk. Because that function is not limited to entities in the insurance industry, the activity that the Virginia law attempts to regulate fails to meet the second

prong of the *Pireno* and *Royal Drug* test for the type of activity that may be deemed the "business of insurance."

In reality, the creation or selection of a PPO is nothing more than a service to a plan sponsor or the plan and, as such, is a function separate and distinct from the provision of insurance. *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). The facts of this case make that point clear: in many instances, Aetna did not provide insurance coverage to the subscribing plans, but merely provided administrative services relating to their subscriptions to the PPO.

Moreover, if the participant population of a plan sponsor were large enough, any such sponsor could command the attention of significant numbers of health care providers and thus create its own PPO network through its own selection process. In such a case, there would be no doubt that the "deemer" clause of ERISA § 514 would preclude the characterization of such a plan as an insurer and, hence, the application of any state insurance laws to such a plan. *See Metropolitan Life, supra.* Clearly, the hiring of an insurance company by the plan sponsor, either directly or indirectly, to create or provide a PPO network should not change the legal analysis that the "deemer" clause protects this activity. Indeed, such a service provider, whether an insurance company or another entity, is nothing more than an extension of the plan and its sponsor and, as such, shares in the "deemer" clause protection given the plan.

If Virginia's law is allowed to stand, it will have the adverse impact of denying small plans the advantages of the mega-plans. Unlike large plans, small plans and their sponsors do not have the economic clout or the numbers of potential patients necessary to attract and form independently cost-efficient PPO networks. Denying small plans the aid of insurance companies in the formation of cost-efficient PPO networks has the effect of denying them the easiest and least costly means of participating

in a PPO network. That, in turn, clearly has a direct impact on the design, operation and economics of those small plans.

C. The Law Does Not Affect The Relationship Between The Insurer and The Insured. Because the relationship between the entity that creates or administers a PPO network and any particular subscriber plan is purely and simply one of a service provider to such plan—and not one in which any type of risk is shifted—the activity that Virginia's "any willing provider" law attempts to regulate is not an activity that affects the relationship between an insurer and an insured. The activity being regulated by Virginia law is an activity that any entity, including the plan or its sponsor, could perform and involves no shifting of risk necessary to an insurance relationship. Although the Virginia law is strictly limited in application to insurance companies engaged in offering or administering PPO networks, it does not so regulate any insurer in its capacity as an insurer. Hence, the Virginia "any willing provider" law does not affect the relationship between an insurer and an insured, and thereby fails to meet the third and final prong of the *Pireno* and *Royal Drug* test.

The Fourth Circuit's contrary conclusion warrants this Court's review. That decision is inconsistent with this Court's established principles of ERISA preemption. *See Metropolitan Life*, 471 U.S. at 740. And it is irreconcilable with basic notions of risk in the insurance context. *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. at 211-12.

II. THE DECISION BELOW WILL CREATE A SIGNIFICANT DISRUPTION IN THE EMPLOYEE BENEFIT COMMUNITY AND THREATENS TO ELIMINATE AN IMPORTANT MEANS FOR REDUCING THE NATION'S HEALTH CARE COSTS.

If the Fourth Circuit's decision is allowed to stand, an important weapon in the fight to control and, indeed, reduce this nation's health care costs will be eroded. This

is evidenced by the fact that, as of 1992, nearly 40 percent of all employers in the United States offered their employees some form of PPO, and nearly 58 million employees and dependents accepted these offers by participating in PPOs. American Association of Preferred Provider Organizations, "PPO Growth" (1993). The application of Virginia's "any willing provider" law will result in an increase in administrative costs while decreasing claims savings. Moreover, and more importantly, depending on the number of providers using the law to gain admittance to any particular PPO, the law will actually devalue the PPO as a cost-saving mechanism by eliminating its ability to provide any marginal savings as compared to other non-PPO providers. Report to Health Insurance Association of America: Cost Analysis of State Legislative Mandates on Six Managed Health Care Practices, at 1-5 (Wyatt Co. 1991).

Cost efficiency is a legally permissible goal for plan sponsors. It should not be impermissible for plan sponsors to hire independent experts to aid them in their selection of plan service providers. Indeed, to the extent that any particular employee welfare benefit plan receives monies from plan participants for the purpose of defraying the costs of its offered benefits or the premiums supporting the insurance coverage for such benefits, the plan's fiduciaries have a duty under ERISA's fiduciary responsibility provisions to expend those assets as prudently as possible. The Virginia law would impede plan fiduciaries from fulfilling this responsibility and obligation to the best of their ability by eliminating a source of cost-efficient medical services. This is particularly true for smaller employers that do not have the economic power to negotiate successfully with individual health care providers to create their own PPO networks.

Not only do such results have a negative impact on the nation's health care costs, they are also entirely at odds with the words and intent of ERISA. Although ERISA

does not provide specific substantive design requirements for welfare plans, the resulting "regulatory void" merely evidences Congressional intent to leave those subjects to the discretion of plan sponsors. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981); *Standard Oil of Calif. v. Agsalud*, 442 F. Supp. 695, 705 (N.D. Cal. 1977), *aff'd*, 633 F.2d 760 (9th Cir. 1980), *aff'd*, 454 U.S. 801 (1981). Lack of specific ERISA regulation does not give states the authority to fill in the "regulatory void." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98-99 (1983). Indeed, if states like Virginia are permitted to interfere with sponsor discretion, plan sponsors will be required to conform to a patchwork of state-mandated requirements concerning the offering of a PPO network or to eliminate the PPO option altogether.[4]

It is just such a result that ERISA's preemption provisions were meant to avoid. As this Court stated in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987):

> A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits.

The Court explained in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 105 & n.25:

> ERISA's comprehensive preemption of state law was meant to minimize this sort of interference with the administration of employee benefit plans, . . . [so

[4] Currently, several States have various types of "willing provider" laws. A number of states have laws similar to Virginia, *e.g.*, Georgia (Ga. Code Ann. § 33-20-16 (1990)); Illinois (215 Ill. Comp. Stat. Ann. 5/370h (1993)); Indiana (Ind. Code Ann. § 27-8-11-3 (Burns 1992)); Louisiana (La. Rev. Stat. Ann. § 40:2202 (West 1992)); Utah (Utah Code Ann. § 31A-22-617 (1991)); and Wyoming (Wyo. Stat. § 26-22-503 (1977)). Some states have laws that apply only to certain types of providers or only to certain types of arrangements. *See, e.g.*, Nebraska (Neb. Rev. Stat. § 44-4112 (1988)) and Idaho (Idaho Code § 41-1844 (1991)) respectively.

> that employers would not have] to administer their plans differently in each State in which they have employees.[5]

Allowing the lower court decision to stand will create the type of patchwork regulation that is directly contrary to the maintenance of nationwide employee benefit plans and that Congress intended to preclude through federal preemption.

This case is of nationwide importance. Certiorari should be granted to eliminate the "patchwork" diversity that will result from the Fourth Circuit's decision below.

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[5] The legislative history of ERISA is replete with support for this principle. *See, e.g.*, S. Rep. No. 127, 93d Cong., 1st Sess. 35 (1973), *reprinted in* 1 Legislative History of the Employee Retirement Income Security Act of 1974 (1976) ("Legislative History"), at 621 ("Except . . . in certain . . . enumerated circumstances, state law is preempted. Because of the interstate character of employee benefit plans, the Committee believes it essential to provide for a uniform source of law . . . ."); 120 Cong. Rec. 29,197 (1974) (Representative Dent) (broad federal preemption was designed to eliminate "the threat of conflicting and inconsistent State and local regulations"); 120 Cong. Rec. 29,933 (Senator Williams) ("the substantive and enforcement provisions . . . are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans"); 120 Cong. Rec. 29,942 (1974) (Senator Javits) ("the emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required—but for certain exceptions—the displacement of State action in the field of private employee benefit plans").

CONCLUSION

For the reasons set forth above and for the additional reasons advanced in the Petition, the writ of certiorari should be granted.

Respectfully submitted,

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IN THE
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AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,
Petitioners,

v.

STUART CIRCLE HOSPITAL CORPORATION,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF *AMICUS CURIAE* OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS IN SUPPORT OF PETITIONERS

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MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE*

To the Honorable Chief Justice and Associate Justices of the Supreme Court of the United States:

Pursuant to Rule 37 of the Rules of this Court, the National Coordinating Committee for Multiemployer Plans (the "NCCMP") respectfully moves this Court for leave to file the accompanying Brief *Amicus Curiae* to urge the Court to review the decision below, which raises an issue of great national importance with regard to ERISA pre-emption; more specifically, the scope of the "insurance regulation" exemption. Petitioners have consented to the filing of this Brief; Respondent has not. The letters granting and refusing consent have been filed with the Clerk of the Court.

The NCCMP is a nonprofit, tax-exempt organization that was formed after ERISA's enactment in order to participate in the further development of employee benefits legislation and the promulgation of government regulations to implement ERISA and other laws affecting multiemployer plans. Currently, more than 200 multiemployer plans and related international unions, located in at least 37 states, are affiliated with the NCCMP. These plans provide benefits to a majority of the more than nine million workers who are covered by the nation's multiemployer plans.

Because of the broad range of the NCCMP's constituent organizations and its contacts with hundreds of trustees charged with the administration of multiemployer plans in accordance with ERISA's fiduciary duty rules and principles, the NCCMP believes that it is qualified to advise the Court of the practical implications of the decision below for multiemployer health plans and to state the position of the trustees, participants, and beneficiaries of such plans. The NCCMP has participated as *amicus curiae* in numerous cases involving issues affecting multiemployer plans. *See, e.g., Local 144 Nursing Home Pension Fund, et al. v. Demisay*, —— U.S. ——, 113 S. Ct. 2252 (1993); *Concrete Pipe & Products of California v. Construction Laborers Pension Fund for Southern California*, —— U.S. ——, 113 S. Ct. 2264 (1993); and *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

In the instant case, we respectfully request this Court to review the important question whether Virginia's "any willing provider" statute, which regulates membership in Preferred Provider Organizations ("PPOs") marketed by insurers to employee benefit plans, is preempted by ERISA. The court below ruled that the law is "saved" from ERISA preemption because the statute regulates the "business of insurance," as distinct from the "business of insurers." The ruling thus expands the "savings" clause at the expense of the preemption clause by defining the "business

of insurance" in a manner inconsistent with this Court's precedents and Congressional intent. For this reason alone, the NCCMP urges review of the decision.

More specifically, multiemployer health plans, including many NCCMP affiliates, are increasingly utilizing the PPO form of managed care to respond to the escalating costs of providing covered health benefits. Cost containment is achieved through the PPO because the providers are able to deliver health care services at discounted rates. However, economic studies have shown that PPOs can deliver health care services at discounted rates only if membership is limited so that providers are assured sufficient patient volume to justify the discount. Such studies have demonstrated that the competition generated by limiting membership in PPOs also improves the quality of the health care they provide. The Virginia law, however, bars insurers from excluding any provider willing and able to meet the PPO's membership requirements, regardless of need.

The NCCMP submits that the decision below will have far-reaching adverse consequences for multiemployer health plans. If the Virginia law is upheld, PPOs offered by insurers will be eliminated from the market available to multiemployer plans both because they will not be able to provide the requisite discounts and because the trustees may not be able to perform their fiduciary obligation of assuring that the PPO selected is offering the highest quality health care at reasonable cost. Since states other than Virginia have or are considering "any willing provider" statutes, and since PPOs offered by insurers (including Blue Cross) are a large and reliable resource for multiemployer plans, elimination of such PPOs from the market available to multiemployer plans will undermine the viability of PPOs, in general, as a cost-containment mechanism in today's health care environment.

The NCCMP will focus its discussion upon the practical consequences of the decision below for multiemployer

plans, a topic on which the NCCMP is uniquely able to provide information.

Based on the foregoing, the NCCMP respectfully moves for leave to file the accompanying Brief *Amicus Curiae*.

Respectfully submitted,

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BRIEF *AMICUS CURIAE* OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS IN SUPPORT OF PETITIONERS

INTRODUCTION

The National Coordinating Committee for Multiemployer Plans (the "NCCMP") files this Brief *Amicus Curiae* to urge this Court to review the decision below, which contradicts the premises of ERISA preemption, is fundamentally inconsistent with previous decisions of this Court, and undermines the viability of Preferred Provider Organizations ("PPOs") as a cost-containment mechanism for multiemployer plans by effectively eliminating access to a whole class of PPOs.

INTEREST OF THE NCCMP

The nature, purpose, and interest of the NCCMP is set forth in the accompanying Motion for leave to file this brief.

SUMMARY OF REASONS FOR REVIEW

By enacting ERISA, Congress sought to enhance the financial stability of multiemployer plans and to foster the growth and maintenance of such plans. 29 U.S.C. § 1001. The decision below is inconsistent with those goals because it seriously limits the ability of plan trustees to respond to the national health care crisis—pending national health care reform—by freely selecting PPOs on a competitive basis to deliver high quality, low cost health care to plan participants and their families, and thereby to stem the drain on plan assets caused by escalating health care costs.

PPOs are intermediary organizations that arrange for third-party payers, such as employee benefit plans, to purchase health care for their subscribers or participants.[1] As such, PPOs may be viewed as a line of business that offers a product representing a variation of traditional fee-for-service arrangements. Like the latter, PPO administrators enter into contracts with health care providers to deliver the services covered by employee benefit plans at specified fees. However, because PPO administrators typically contract with a limited number of carefully selected health care providers, covered services can be delivered at substantially discounted rates since the preferred providers are assured a sufficient volume of patients to permit the discount.

In response to the spiraling costs of providing health care, self-funded multiemployer plans are increasingly utilizing or are considering utilizing PPOs to contain the

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[1] R. Youle and P. Daw, *Preferred Provider Organizations: An Antitrust Perspective*, Antitrust Bulletin (Summer 1984), p. 302.

costs of providing covered benefits. If the multiemployer plan has a sufficient number of participants in a geographical community, it may be feasible for the plan to establish its own PPO network in that locality and to negotiate directly with health care providers to secure the best possible rates. However, this is relatively unusual. Therefore, multiemployer plans must normally rely heavily on PPOs offered by insurance companies or on PPOs marketed by other entities such as associations of doctors or other health care providers.

At issue in this case is a Virginia law that regulates membership in PPOs offered by insurers such as Petitioners or Blue Cross (considered to be an insurer for purposes of the statute). Va. Code Ann. § 38.2-3407. Like the "any willing provider" statutes of other states, the Virginia law undermines the ability of these PPOs to deliver health care services to multiemployer plans at discounted rates because the statute prohibits the insurer from limiting the number of preferred providers; irrespective of need, the law prohibits the exclusion of any provider willing and able to meet the terms and conditions established by the insurer for membership in its PPO.

Although the Fourth Circuit agreed with the district court that the Virginia law "relates to" employee benefit plans and is therefore preempted under Section 514(a) of ERISA, 29 U.S.C. § 1144(a), the court of appeals held that the statute was "saved" from preemption under Section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), because the statute regulates the "business of insurance," as distinct from the "business of insurance companies."

In so ruling, the court of appeals departed from this Court's consistent reading of the McCarran-Ferguson Act, 15 U.S.C. § 1101 *et seq.*, and its narrow construction of the "business of insurance." *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982); *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), *cert. denied*, 469 U.S. 1160 (1985). As a result, the court

unjustifiably expanded ERISA's "savings" clause at the expense of its preemption clause. If this decision stands and is followed, self-funded multiemployer plans will be exposed to a patchwork of state PPO regulations, since a number of states have or are considering laws similar to Virginia's. Under these laws, insurers cannot offer limited-panel PPOs to self-funded plans, even if it were practically and economically feasible to do so. The NCCMP seeks review because of its concern that the Fourth Circuit's ruling has impermissibly eroded the broad reach of ERISA preemption that Congress intended and that has been consistently upheld by this Court.

Whether or not the marketing and administration of a PPO constitutes the "business of insurance" for purposes of ERISA preemption is clearly an issue of great importance, as it adversely affects the ability of multiemployer plans to secure the delivery of health care at discounted rates by effectively eliminating a whole class of PPOs from the managed health care market available to such plans.

While it is true that "any willing provider" statutes like Virginia's do not regulate membership in PPOs, other than those established by insurers, PPOs established by insurers (including Blue Cross) form a major and reliable resource for multiemployer plans. Unless the Fourth Circuit's ruling is reviewed and reversed, however, multiemployer plans will no longer be able to utilize PPOs marketed by insurers in states having "any willing provider" statutes because those PPOs will not be able to deliver health benefits at discounted rates. Moreover, even if benefits could be provided at a reasonable discount, state laws such as Virginia's interfere with the fiduciary obligation of the trustees of multiemployer plans to ensure that the PPO it utilizes is of the highest quality and has an effective selection process for including and excluding providers.

Since it is well-established that limited-membership PPOs are intended to lower consumer prices by organiz-

ing only the most efficient health care providers, thereby permitting lower costs and higher quality through economies of scale, the elimination of PPOs offered or administered by insurance companies from the market open to multiemployer plans in states having "any willing provider" statutes is not only anticompetitive but inconsistent with the objectives of ERISA. The NCCMP therefore seeks review because there is no justification for including the marketing and administration of such PPOs within the definition of the "business of insurance" so as to save the Virginia law and similar state laws from ERISA preemption.

REASONS FOR REVIEW

THE DECISION BELOW WILL PLACE SERIOUS LIMITS ON THE ABILITY OF MULTIEMPLOYER PLANS TO SECURE HIGH QUALITY, COST-EFFECTIVE HEALTH CARE, RAISES AN ISSUE OF GREAT NATIONAL IMPORTANCE WITH REGARD TO ERISA PREEMPTION, AND IS INCONSISTENT WITH THIS COURT'S PREVIOUS DECISIONS

A. The Decision Below Diminishes the Viability of PPOs as a Cost-Containment Mechanism for Multiemployer Plans

The NCCMP endorses the reasoning of the district court [2] and therefore supports the arguments advanced in the Petition for Certiorari. In urging review, the NCCMP will focus primarily on the adverse impact which the Fourth Circuit's decision is likely to have on the ability

[2] *Stuart Circle Hospital Corp. v. Aetna Health Management*, 800 F. Supp. 328 (E.D. Va. 1992). The NCCMP also endorses the reasoning of Chief Judge Cacheris in a similar case, *HCA Health Services v. Aetna Life Ins. Co.*, 803 F. Supp. 1132 (E.D. Va. 1992), in which the court, in a lengthy and well-reasoned opinion, likewise concluded that Va. Code Ann. § 38.2-3407 was not saved from preemption because the statute does not regulate the business of insurance under this Court's tests.

of multiemployer plans to secure high-quality, cost-effective health care through contractual arrangements with PPOs—a perspective that the NCCMP is uniquely able to provide.

By way of background, it may be recalled that multiemployer health plans are created pursuant to collective bargaining agreements and are funded by contributions made by more than one employer, which are pooled to pay benefits on behalf of all of the plan's participants and beneficiaries. Employers and unions negotiate the amount of money they are willing to allocate to providing health benefits for their employees. However, the plan documents of multiemployer plans normally give trustees sole discretion to determine the type of benefits that the plan will provide as well as the amount of money the plan will pay for each covered benefit.

Typically, the plan of benefits enumerates the plan's eligibility requirements, the specific benefits covered, the specific benefits excluded, restrictions and limitations on the benefits provided (such as lifetime ceilings and coordination of benefits), the participant's obligations (including deductibles, copayments, and subrogation) and information concerning the submission of claims and the right to appeal. The contents of this plan are then summarized in a "summary plan description" which the plan must furnish to its participants in accordance with ERISA's reporting and disclosure requirements.[3]

While a multiemployer plan may utilize the services of a third-party administrator or an insurance company to administer the plan, benefit design issues are solely within the jurisdiction of the board of trustees, and only the trustees have the ability to determine whether a service is covered as a benefit under the plan. Analogizing to insured plans,[4] a multiemployer plan of benefits constitutes

[3] 29 U.S.C. §§ 1022, 1024(b).

[4] An "insured plan" is a plan in which group health coverage is provided through an insurance policy. Insured plans are subject

the insurance contract with its participants and beneficiaries because it sets forth the risks which the plan will assume (*e.g.*, covered benefits) as well as those which remain with the participant (*e.g.*, limitations on coverage, exclusions, specific obligations).

In an effort to control costs while ensuring that high quality medical care is available for their participants and beneficiaries, multiemployer plans are increasingly utilizing or are considering utilizing PPOs or some other form of managed care.[5] Economic studies[6] have shown that man-

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to state regulation of insurance companies. However, self-funded plans are "deemed" not to be insurers for purposes of state laws regulating insurance and are therefore not bound by state laws regulating insurance. 29 U.S.C. § 1144(b)(2)(B). *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) and *FMC Corp. v. Holliday*, 498 U.S. 52 (1990). The court below clearly recognized this distinction, noting that the Virginia law regulating membership in the PPOs of insurers could not prohibit self-funded plans from establishing limited-membership PPOs themselves or from utilizing limited-membership PPOs marketed by noninsurers. However, the "deemer" clause, which normally affords self-funded plans significant protection against state laws, is of no practical significance with regard to "any willing provider" statutes because insurance companies do not have separate networks for insured and self-funded plans. Moreover, since the Virginia law does not focus on the *purchaser* of the PPO, it would appear to bar insurers from offering limited-memership PPOs to self-funded plans, even if the insurer could establish and market separate PPO networks, *infra*.

[5] Managed care involves control over quality, utilization, and claims and can be provided through a variety of forms such as PPOs, HMOs, or some variation thereof. The use of PPOs has increased so dramatically within the managed health care industry that an accreditation program has now been established just for PPOs. Major foci of the accreditation process are provider selection and quality assessment. As one reviewer has stated, "Most doctors see managed care as having strictly a cost-saving emphasis. Though that's obviously important, no matter how much money a PPO saves, there still must be an emphasis on quality." *See* Nancy N. Bell, *The AAPI Accreditation Program*, Medical Interface (April 1991), pp. 23, 27.

[6] *See, for example, Report to Health Insurance Association of America: Cost Analysis of State Legislative Mandates on Six*

aged care plans, including PPOs, are much better able to control costs than traditional fee-for-service [7] or indemnity

Managed Care Practices (Wyatt Company 1991); *see also* Letter of Michael O. Wise, Acting Director of the Federal Trade Commission to the Attorney General of Montana, dated February 4, 1993, discussing the anticompetitive and cost-increasing effects of "any willing provider" laws. The principal purpose of Mr. Wise's letter was to set forth the views of the staff of the Federal Trade Commission with regard to Montana's "any willing provider" statute, Mont. Code Ann. § 33-22-1704 (Temporary), due to expire in July 1993. The letter indicates that, as a general principle, PPOs moderate increases in health care costs and that lower premiums are attributable to competition among health care providers. Conversely, since "any willing provider" statutes are anticompetitive, FTC staff believes that these laws may result not only in increasing consumer prices but in restricting consumer choice if PPOs are unable to deliver health care at discounted rates. (Since the Montana statute is similar to Virginia's, the above letter has been reprinted in full as Appendix E to the Petition (35a-43a).)

Similarly, as reported by The Segal Company, a recent survey by *Business Insurance* magazine has found that plans renewing their contracts in mid-1993 are experiencing 18-22 percent increases in premiums for indemnity coverage, as contrasted with 12-18 percent increases for PPOs. *See Managed Care for Multiemployer Plans: Experience and Outlook*, The Segal Company Newsletter, Vol. 37, Nos. 2 and 3 (Sept. 1993), pp. 3-4. (The Segal Company is a nationally known consultant to multiemployer plans, including numerous NCCMP affiliates, and works with plans to obtain high quality care at reasonable cost.)

It may also be noted that the previous Administration, utilizing demonstration models, has sought to establish PPOs as an arrangement to improve the delivery and cost of health care services provided to participants in the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The Department of Defense has noted that both the beneficiary and the program sponsor can stand to benefit because of discounts offered by PPO providers, and that providers stand to benefit by increasing their market share. 53 Fed. Reg. 19323-01 (1988).

[7] "Fee-for-service" refers to a traditional means of billing by health care providers for each service performed. PPOs achieve cost-savings because network providers agree to provide services on a fee-for-service basis at a discounted rate. The reduction may consist of a percentage of the plan's fee schedule based on what

plans. In 1990, for example, 27 small multiemployer plans covering primarily building trades workers in Washington, D.C., Baltimore, Maryland, and Richmond, Virginia, established an organization to negotiate lower rates with PPOs, prescription drug programs, and utilization services. The plans provided health care coverage to approximately 25,000 workers and 50,000 eligible dependents. In the first year of its operation, the Health Care Cost Containment Corporation of the Mid Atlantic Region ("HCCCC") saved the plans a total of $12 million: $4.66 million (38 percent) in physician costs, $3.85 million (32 percent) in hospital costs, and $3.49 million (29 percent) through utilization management. According to The Segal Company, total negotiated discounts in the first quarter of 1993 reached nearly $5 million. As of July 1993, 41 funds covering 43,000 workers now participate.[8]

The trustees of plans selecting the PPO form of managed care frequently adopt a PPO plan in combination with a non-PPO plan, permitting the participant to select which plan he or she desires to utilize to obtain health care. In this case, participants are free to use any of the physicians or health care facilities within the PPO network. Although participants are not penalized or prevented from using non-PPO providers, the PPO plan will generally include important incentives that encourage its use,

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is "usual" (the provider's normal charge), "customary" (the normal charge for similar providers in the area), and "reasonable" (the charge the plan is prepared to pay, also referred to as the "allowable charge" for the service). Or, cost-savings may be achieved through independently negotiated fee schedules; for example, based on the number of "bed days" rather than itemized hospital charges. Or, the PPO providers may agree to accept a reduced percentage of a plan's standard fee schedule based on relative value scales. Relative value scales establish uniform charges for all procedures and services based on the perceived value of those procedures and services with respect to one another.

[8] The Segal Company Newsletter, *supra*, pp. 11-12.

so as to permit the plan to take advantage of the cost-savings generated by the use of PPOs.

The following example, provided by an NCCMP affiliate, illustrates the operation of a combined PPO non-PPO plan and the incentives for a participant's remaining within the PPO network:

> A participant seeks care for a heart ailment. The participant's physician recommends that a mitral valve replacement be performed. The Trustees determine that mitral valve replacement is a procedure covered by the plan and that the participant is eligible for benefits. The plan's utilization review board certifies that the procedure can be performed within the PPO network.[9]
>
> If the participant receives mitral valve replacement at a PPO hospital, the participant will be reimbursed at the rate of 80 percent of allowable (*e.g.*, contracted) charges for hospital care and 80 percent of allowable (*e.g.*, contracted) charges for the surgeon. The participant pays the remaining 20 percent.
>
> If the participant goes outside of the PPO for the mitral valve procedure, the participant will be reimbursed at the rate of 60 percent of the plan's fee schedule for the procedure; the participant will pay 40 percent. However, regardless of the cost of

[9] Managed care programs usually include a utilization review system ("UR"), which provides for preadmission hospital review, second surgical opinions, review during hospital stays, and alternative treatment options (for example, outpatient versus inpatient). UR programs contain costs by determining whether a treatment is appropriate and necessary and also, where such services should be provided. As a matter of plan design, the decision to adopt a UR program lies within the sole discretion of the trustees. Typically, the fund will then contract with a third party, other than the PPO, to provide UR. If the UR provider determines that a particular procedure cannot be performed within the PPO network, participants will usually be permitted to obtain treatment from a non-PPO provider without incurring the penalties that otherwise provide the incentive to remain within the PPO.

> the hospital and surgical fees, the plan will pay only a maximum of $15,000 per hospital stay and $8,000 to the surgeon for the mitral valve replacement.

In this example, the participant not only pays a 20 percent larger share of the costs of the treatment; he or she may also be required to pay a higher share of a higher charge.[10] In addition, benefits are capped, which is very significant in the event of major illnesses.

If a multiemployer plan has a sufficient number of participants in a particular geographical location, the plan may be able to establish its own PPO network by negotiating directly with health care providers to obtain the best terms possible. This is the exception, not the rule, particularly since the American Accreditation Program, Inc. ("AAPI"), the accrediting vehicle of the American Association of Preferred Provider Organizations ("AAPPO"), will not accredit a PPO unless it provides services to at least 6,000 participants, and PPOs are relatively circumscribed geographically in order to provide reasonable access to health care providers.

Therefore, multiemployer plans adopting the PPO-form of managed care must rely on insurers such as Petitioners or Blue Cross or other insurers who market or administer PPOs. As amply pointed out by Petitioners and in the literature cited in their brief, including the opinion of FTC staff, PPO's are able to deliver health care at discounted rates only if the PPO is able to limit its mem-

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[10] An example of this would be where a hospital PPO arrangement provides for reimbursement of all hospital costs based on "bed days," whereas the non-PPO plan has standard charges for specific procedures. Assume the usual, customary, and reasonable charge for a procedure is $15,000, but the PPO plan pays $900 per bed day. The participant has the procedure performed in a hospital and stays three days. If the participant chooses the PPO provider, he will be liable (at most) for 20 percent of $2,700 (3 × $900) or $540. If the participant chooses a non-PPO provider, he will be liable for 40 percent of $15,000 or $6,000. Clearly, the plan and the participant save by utilizing a PPO hospital.

bership to assure a sufficient volume of patients to justify the discount.[11]

"Any willing provider" statutes, such as Virginia's, prohibit PPOs from limiting the number of providers. As stated in the FTC opinion letter,

> Requiring that programs be open to all providers wishing to participate on the same terms may affect both costs and coverage. To the extent that opening programs to all providers reduces the portion of subscribers' business that each contracting provider can expect to obtain, these providers may be less willing to enter agreements that contemplate lower prices or additional services. Moreover, since any provider would be able to contract on the same terms as other providers, there would be little incentive for providers to compete in developing attractive or innovative proposals. Because all other providers can "free ride" on a successful proposal formulation, innovative providers may be unwilling to bear the costs of developing a proposal. Thus "any willing provider" requirements may substantially reduce provider competition for this segment of their business.

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[11] One NCCMP affiliate reports that it gradually phased in a PPO network, with both physicians and hospitals, as follows. The plan originally reimbursed physicians under a standard fee-for-service plan at a rate that was within the 85th percentile of the fee schedule adopted by the trustees, which was based on the California Relative Value Scale. In an attempt to control costs, the plan reduced the amount of reimbursement from the 85th percentile to the 70th percentile. However, in order to achieve more significant cost-savings, the plan contracted with an insurance carrier to purchase a PPO for the geographic area in which its participants were located. The PPO saved approximately 2 percent in physician costs. However, the PPO saved approximately 15 percent in hospital costs. It is anticipated that this PPO network will be decreased from several thousand to several hundred physicians. Cost-savings to be derived from downsizing the PPO network are expected to amount to an additional 5 to 10 percent. While the physicians in the smaller PPO will receive lower reimbursement, they will receive a greater volume of business.

> Reduced competition among providers for PPO business can result in higher prices for services through PPOs. The higher prices for covered services, as well as the increased administrative costs associated with having to deal with many more providers, may raise the prices to subscribers for prepaid health care programs, or may force those programs to reduce benefits to avoid raising those prices. (Petition, App. E, 41a-42a.)

Similarly, The Wyatt Company's evaluation of the impact of "any willing provider" statutes on administrative costs- and claims-savings concluded that a point exists where a PPO will be unable to sustain any marginal value to the community if it is forced to accept more than a limited percentage of providers, assuming that the average provider must either increase utilization or accept smaller discounts to maintain the current level of net income or operating margins.[12]

The NCCMP has been advised by various insurers that insurance companies in states having "any willing provider" statutes do not have separate PPO networks for multiemployer plans. Moreover, the Virginia law makes no distinction between PPOs offered to self-funded multiemployer plans and PPOs offered to other subscribers. Therefore, even if it were economically or administratively feasible for an insurer to offer different PPO networks to different subscribers, the Virginia law would not permit the insurer to exclude willing providers merely because the insurer is offering the network to a multiemployer plan.

Consequently, although "any willing provider" laws, such as Virginia's, were apparently designed to give consumers an unlimited choice of providers, such laws, if allowed to stand, will have the opposite effect on multi-

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[12] *Report to Health Association of America: Cost Analysis of State Legislative Mandates on Six Managed Care Health Practices* (Wyatt Company, 1991).

employer plans and their participants and beneficiaries. First, multiemployer plans wishing to adopt the PPO form of managed care will have to rely on PPOs other than those marketed by insurers in states having such laws. Or, these plans will have to utilize other forms of managed care. In either case, consumer choice will be reduced. In addition, since PPOs offered or administered by insurers represent a very large resource, elimination of these PPOs from the market available to multiemployer plans is likely to result in lower discounts, since the remaining PPOs will be better able to adopt a "take it or leave it" posture, given the reduced competition. This, too, will adversely affect the consumer.

Moreover, as the AAPPO and its accrediting vehicle, the AAPI, recognize, quality is as important a factor as cost-containment. Indeed, this factor is particularly important with regard to multiemployer plans governed by ERISA, whose trustees have a fiduciary obligation to select PPOs that are not only cost-effective but provide the highest quality care, and to monitor—either themselves or through the entity offering the PPO—the providers delivering services to plan participants.

Apart from cost, bigger PPOs are not necessarily better because the selection criteria may not be very stringent. "Any willing provider" laws exacerbate the problem of quality control because PPOs offered by insurers must include even marginal providers as long as they satisfy the basic membership criteria instead of limiting membership to the best providers having an established track record of providing high quality care at reasonable cost. If the PPO cannot demonstrate that it is committed to identifying and, if necessary, terminating inferior or aberrant providers, notwithstanding the risk of lawsuits, the trustees of multiemployer plans may not be able to assure the quality of service in a manner sufficient to comply with ERISA. For this reason too, "any willing provider" statutes may result in the elimination of PPOs offered

by insurers from the market available to multiemployer plans. The effect of "any willing provider" statutes on the financial soundness of multiemployer plans is therefore an issue of great national importance, since numerous states have or are considering such laws.[13]

The NCCMP also seeks review because of its fundamental belief that the health care crisis must be resolved by national health care reform, not by piecemeal state legislation which, if enforced by federal courts, could cripple multiemployer plans. In this regard, it is significant that the President's Health Care Reform Plan endorses limited-provider plans. Thus, while corporate alliances may offer a traditional indemnity plan, they must also offer at least two other plans. *Notwithstanding state laws to the contrary*, such plans are authorized to:

- Limit the number and type of health care providers who participate in the health plan.
- Require participants to obtain health services other than emergency services from participating providers or from providers authorized by the health plan.
- Establish different payment rates for participating health providers and providers outside the plan.
- Create incentives to encourage the use of participating providers.
- Use single-source suppliers for pharmacy, medical equipment, and other health products and services.[14]

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[13] As noted in Petitioners' brief, the following states already have "any willing provider" statutes similar to Virginia's: Georgia, Illinois, Indiana, Louisiana, Utah, and Wyoming. According to a report issued by the Group Health Association of America, dated September 15, 1993, 15 states have or are introducing some form of "any willing pharmacy" law. If the Fourth Circuit's opinion is sustained, other states may be encouraged to expand such laws to regulate membership in PPOs.

[14] *Clinton Administration Description of President's Health Care Reform Plan, American Health Security Act of 1993, dated Sep-*

Since "any willing provider" laws are inconsistent with the goals of national health care reform, and are demonstrably anticompetitive, there is no justification for "saving" these state laws from ERISA preemption, particularly since the marketing and administration of PPOs by insurance companies is clearly not the "business of insurance" under this Court's precedents.

B. The Decision Below Raises an Issue of Great National Importance With Regard to ERISA Preemption and Is Inconsistent With This Court's Precedents

This Court has repeatedly emphasized that "ERISA preempts any state law that refers to or has a connection with covered benefit plans (and that does not fall within a § 514(b) exception) even if the law is not specifically designed to affect such plans, or the effect is only indirect." *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. ——, 121 L.Ed.2d 513, 520 (1992) (citations omitted). The issue in this case is therefore whether Virginia's "any willing provider" law falls within a § 514(b) exemption since there is no dispute that the law "relates to" employee benefit plans.

Section 514(b)(2)(A) exempts from preemption state laws that "regulate insurance." However, ERISA does not further define insurance regulation. Therefore, to determine whether a state law falls within the § 514(b) insurance exemption, this Court and all lower courts faced with the issue have drawn upon the criteria for determining whether a particular practice constitutes the "business of insurance" within the meaning of the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.* If the state law regulates a "practice" that constitutes the "business of insurance," it is saved from ERISA preemption, except as applied to self-funded employee benefit plans. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S.

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tember 7, 1993, BNA Special Supplement (September 13, 1993), S-25.

724 (1985) (holding that state-mandated benefit laws are saved from preemption, except as applied to multi-employer plans, because they regulate the substantive terms of insurance contracts and otherwise meet the McCarran-Ferguson criteria).

In the case at bar, the Fourth Circuit ruled that PPO arrangements between insurers and service providers constitute the "business of insurance." The court therefore ruled that the Virginia law, which regulates membership in PPOs offered by insurers, is "saved" from ERISA preemption. The NCCMP concurs fully with Petitioners that the Court below failed to distinguish between the "business of insurance" and the "business of insurers" and, in so doing, departed from the distinction carefully crafted by this Court in *Group Life Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979) and *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982).

Specifically, the NCCMP agrees with Petitioners that *Royal Drug* is dispositive of the case at bar. In *Royal Drug*, this Court ruled that certain pharmacy agreements, which permitted Blue Shield's insureds to purchase prescription drugs from participating pharmacies more cheaply and more conveniently than from nonparticipating pharmacies, did not constitute the "business of insurance" for purposes of the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.* In making this determination, the Court stated, first, that the pharmacy agreements between Blue Shield and the pharmacies did not underwrite or spread the policyholder's risk, an indispensable characteristic of insurance, because they were merely the vehicle by which Blue Shield could deliver the promised or insured benefit (*e.g.*, prescription drugs) at lower cost to itself and to its policyholders. Second, the Court found that the agreements were not part of the integral relationship between Blue Shield and its insureds, since the contracts were not *between* the insurer and the insured. Finally, the Court found that the agreements did not constitute the "business

of insurance" because they were separate contractual arrangements for goods and services with third persons wholly outside of the insurance industry. The Court indicated that even if Blue Shield acquired its own chain of drugstores to further lower the costs of meeting its obligations to policyholders, this would not be the "business of insurance."

The PPO arrangements between insurers and the health care providers which these insurers accept for membership in their PPOs are the functional equivalent of the pharmacy agreements in *Royal Drug*. First, the PPO contracts do not underwrite risk; they merely serve as the vehicle through which third-party payers, such as employee benefit plans, may fulfill their obligation to provide covered benefits at lower cost to themselves and their participants. Second, the PPO contracts do not regulate the relationship between the insurer and the insured, but only the relationship between the insurer and the preferred provider. Finally, the PPO contracts are not limited to persons or entities in the insurance industry, since the preferred providers themselves are wholly outside this industry. Accordingly, the PPO contracts cannot be reasonably construed to constitute the "business of insurance." Therefore, the Virginia law which regulates these contracts should not be saved from ERISA preemption, as the district court correctly found.

The NCCMP submits that review is necessary to restore the "business of insurance" definition to the precise and narrow limits intended by Congress and articulated by this Court to protect multiemployer plans from a patchwork of state regulation, which protection Congress sought to provide by making employee benefit plans the exclusive concern of federal law.

CONCLUSION

Limited-membership PPOs are essential to contain costs in today's health care environment, and have already been endorsed by the Administration in its proposal for national health care reform. Conversely, open-membership PPOs, which "any willing provider" statutes are designed to protect, are anticompetitive and inconsistent with the objectives both of the McCarran-Ferguson Act and ERISA. The Court below, misconstruing this Court's precedents, upheld Virginia's law by construing PPO arrangements as the "business of insurance." The Court thereby expanded ERISA's savings clause (§ 514(b)(2)(A)) at the expense of ERISA's preemption clause (§ 514(a)), and issued a ruling inimical to the financial health of multiemployer plans.

For the reasons stated above, the Court should grant the Petition for Certiorari and review the decision of the Court below.

Respectfully submitted,

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No. 93-510

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,
Petitioners,

v.

STUART CIRCLE HOSPITAL CORPORATION,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* AND BRIEF *AMICI CURIAE* OF THE TRAVELERS INSURANCE COMPANY AND BLUE CROSS AND BLUE SHIELD OF THE NATIONAL CAPITAL AREA IN SUPPORT OF PETITIONERS

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MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE*

The Travelers Insurance Company and Blue Cross and Blue Shield of the National Capital Area, a division of Group Hospitalization and Medical Services, Inc., a Member of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans, by its undersigned attorneys, hereby move the Court for leave, pursuant to Rule 37 of the Rules of the Supreme Court of the United States, to appear as *amici curiae* in the above-captioned proceeding in support of the Petition for Writ of Certiorari of Petitioners Aetna Life Insurance Company and Aetna Health Management. This motion and the accompanying conditionally filed brief is made within the time specified by Rule 37.2. The written consent of Petitioners Aetna Life Insurance Company and

Aetna Health Management accompanies this motion and the proposed brief. Stuart Circle Hospital Corporation has refused to consent to the filing of this brief.

The Travelers Insurance Company and Blue Cross and Blue Shield of the National Capital Area * (collectively the *"amici curiae"*) are health insurance companies that also administer preferred provider organizations ("PPOs"). Together, these companies manage over 50 PPOs, which cover more than 2 million individuals across the United States. The *amici curiae* currently manage PPOs subject to the Employee Retirement Income Security Act of 1974 ("ERISA") in Virginia and throughout the nation. Certain of these PPOs may also be subject to the "any willing provider" statute interpreted by the Fourth Circuit in this case, as well as similar statutes in at least fourteen other states. The *amici curiae* are therefore vitally interested in the judicial interpretation of these statutes.

The *amici curiae* believe that the proper interpretation of ERISA and any-willing-provider statutes, particularly by the United States Supreme Court, is important to the public interest, as well as to PPOs, subscribers, and providers. Improper expansion of state statutes into an area regulated by ERISA can significantly raise the costs of health insurance to all Americans. In the view of the *amici curiae*, their experience in PPO administration and health insurance will be helpful to this Court's examination of this important issue.

Through their proposed submission, the *amici* seek to provide a broad perspective on the statutory interpretation questions by highlighting to this Court the critical and substantial issues at stake. The *amici*'s brief does not duplicate arguments raised by the parties. Rather, it explains the important economic and policy reasons for applying ERISA preemption to any-willing-provider stat-

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* Blue Cross and Blue Shield of the National Capital Area provides coverage as a not-for-profit health services plan.

utes. In particular, the proffered brief demonstrates the benefits conferred upon society by PPOs and the threat posed by any-willing-provider statutes to PPOs.

More generally, as commentators have stressed, an *amicus* is often in a superior position "to focus the court's attention on the broad implications of various possible rulings." Bruce Ennis, *Effective Amicus Briefs*, 33 Cath. U.L. Rev. 603, 608 (1984), *quoted in* Robert L. Stern et al., *Supreme Court Practice* 570-71 (1986).

The *amici curiae*'s request for leave to participate will not disrupt the briefing schedule, undermine the orderly presentation of argument, delay in any way the resolution of this action, or inject new or unrelated questions into this litigation. The accompanying proposed brief is submitted conditionally at this time.

WHEREFORE, The Travelers Insurance Company and Blue Cross and Blue Shield of the National Capital Area respectfully request that this Court grant their motion for leave to file an *amici curiae* brief in support of the Petition for Writ of Certiorari of Petitioners Aetna Life Insurance Company and Aetna Health Management.

Respectfully submitted,

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BRIEF *AMICI CURIAE* OF THE TRAVELERS INSURANCE COMPANY AND BLUE CROSS AND BLUE SHIELD OF THE NATIONAL CAPITAL AREA IN SUPPORT OF PETITIONERS

Amici Curiae The Travelers Insurance Company and Blue Cross and Blue Shield of the National Capital Area, a division of Group Hospitalization and Medical Services, Inc., a Member of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans, hereby support the petition for writ of certiorari of Aetna Life Insurance Company and Aetna Health Management ("Aetna") to review the judgment in this case of the United States Court of Appeals for the Fourth Circuit.

INTEREST OF THE *AMICI CURIAE*

The Travelers Insurance Company and Blue Cross and Blue Shield of the National Capital Area (collectively the "*amici curiae*") are health insurance companies that also administer preferred provider organizations ("PPOs"). Together, these companies manage over 50 PPOs, which cover more than 2 million individuals across the United States. The *amici curiae* currently manage PPOs subject to the Employee Retirement Income Security Act of 1974 ("ERISA") in Virginia and throughout the nation. Certain of these PPOs may also be subject to the "any willing provider" statute interpreted by the Fourth Circuit in this case, as well as similar statutes in at least fourteen other states. The *amici curiae* are therefore vitally interested in the judicial interpretation of these statutes.

INTRODUCTION

The Fourth Circuit's erroneous decision in this case threatens the viability of insurer-administered PPOs, a vital and efficient form of delivering health care services. PPOs directed by insurance companies currently cover over 30 million individuals. Since PPOs were introduced in the early 1980s, their popularity has rapidly increased

because they have proven effective in controlling runaway health care costs while still providing consumer choice. PPOs accomplish these twin goals by using the bargaining power derived from a large subscriber base to negotiate lower prices for their subscribers. These lower prices, in turn, ensure a higher patient volume for the PPO's network of health care providers by creating financial incentives for the subscribers to use the participating providers. In so doing, PPOs benefit all segments of society.

The Virginia any-willing-provider statute undermines the ability of an insurer-administered PPO to operate effectively. Shorn of the right to select and limit the number of participating providers, such PPOs are unable to guarantee a higher patient volume. Consequently, they are unable to obtain lower prices for their subscribers. By depriving insurer-administered PPOs of the right to choose the health care providers in their PPOs, and by forcing such PPOs to make their subscribers available to any willing provider, the Virginia statute at issue destroys the economic incentives for either subscribers *or* providers to join these PPOs. The Fourth Circuit's conclusion that such a statute is not preempted thus thwarts ERISA's goal of facilitating efficient, nation-wide employee benefit programs.

The Fourth Circuit arrived at its erroneous conclusion by misconstruing the phrase "business of insurance" and determining that the Virginia statute was "saved" from preemption. In fact, Virginia's any-willing-provider statute does not satisfy any of the three requirements established by this Court for determining whether a regulation governs the "business of insurance." The Virginia law does not affect the spreading of a policyholder's risk; it is not an integral part of the policy relationship between the insurer and the insured; and it is not limited to entities within the insurance industry. The Virginia statute regulates the business of insurance companies, not the "business of insurance." It is therefore preempted by ERISA.

Congress's present consideration of health care reform proposals, most notably that of President Clinton, underscores the need for the Court to review this case. Almost all of the health care plans under review would rely heavily on PPOs. Thus, the question as to whether state laws such as any-willing-provider statutes are preempted will remain, especially because none of the primary proposals currently under consideration would modify the scope of ERISA preemption and the insurance savings clause. In any event, health care reform legislation probably would not be effective for many years. During that extended interim period, any hope that health insurers will be able to control their premium increases must rest on their ability to create efficient and competitive health care programs such as PPOs. Thus, in light of the important social value of PPOs and the critical questions of law presented here, this Court should grant certiorari.

REASONS FOR GRANTING THE WRIT

I. ANY-WILLING-PROVIDER STATUTES DESTROY THE ABILITY OF PREFERRED PROVIDER ORGANIZATIONS TO CONTROL HEALTH CARE COSTS.

This case presents an issue of true national significance. Preferred provider organizations ("PPOs") are an increasingly popular and cost-effective mode of managed health care that has developed recently in response to the severe national problem of escalating health care costs. PPOs are more frequently organized by a non-insurance entity—only 36 percent of PPOs are administered by insurers. The organizing entity enters into contracts with selected hospitals, physicians, and other health care providers. These providers agree to supply services to the PPO's subscribers in accordance with certain standards established by the PPO, most notably relating to price and quality of care. In exchange for furnishing health care to these subscribers on the PPO's terms, the providers obtain either a higher or more secure flow of patients.

The Fourth Circuit's erroneous determination that any-willing-provider statutes are not preempted undercuts the rights of an insurer-administered PPO to select the health care providers it believes can meet its standards, as well as its ability to attract health care providers into its PPOs. Thus, at best, the Fourth Circuit's decision would effectively bar insurance companies from organizing PPOs; at worst, it will eventually frustrate the recognized social utility of PPOs. Eliminating insurer-administered PPOs would cripple the PPO market and disrupt the lives of many PPO participants. In the United States, 54 percent of all PPO subscribers are in PPOs administered by health insurance companies. Marion Merrell Dow, *Managed Care Digest: PPO Edition*, at 7 (1992) [hereinafter "*Managed Care Digest*"]. These several million individuals would be forced to find alternative health benefit plans if insurer-administered PPOs were effectively barred. This Court should grant the writ of certiorari to resolve this issue of profound national importance.[1]

A. PPOs Have Increased Rapidly in Popularity Because They Have Helped To Control Health Care Costs in the United States.

All PPOs share certain characteristics. In its simplest form, a PPO is an intermediary between two groups: subscriber health care recipients and selected health care providers. The PPO organizes health care recipients—usually through large employers—and contracts with the recipients for the payment of premiums. The PPO also selects health care providers that are able to meet its desired terms and restrictions in providing care. The PPO sets a range of discounted rates at which the participating providers must supply their medical services. In return for these lower prices offered by the providers, the PPO guarantees higher patient volume to the providers.[2]

[1] In addition, *amici curiae* adopt by reference the arguments for granting the writ of certiorari set forth in the Petition for Writ of Certiorari filed by Aetna.

[2] *See, e.g.*, David Dranove et al., *The Effect of Injecting Price Competition Into the Hospital Market: The Case of Preferred*

The PPO covers entirely the costs of PPO subscribers in need of medical services who seek care from a PPO-participating provider, except for a small subscriber co-payment (or deductible). If, however, the subscriber wishes to use a non-PPO participating provider, the PPO pays for a lower percentage of the medical expenses instead of the entire amount. *See, e.g.*, David Dranove et al., *The Effect of Injecting Price Competition Into the Health Market: The Case of Preferred Provider Organizations*, 23 Inquiry 419, 421 (1986); H.E. Frech III & Paul B. Ginsburg, *Competition Among Health Insurers, Revisited*, 13 J. Health Pol. Pol'y & L. 279, 284 (1988). Thus, the PPO creates a financial incentive for its subscribers to use PPO-selected providers, although they retain a free choice of providers. Many individuals, when choosing a new doctor or getting a referral, select one from the list of providers designated by the PPO, leading to increased patient volume for the PPO-participating providers.

The popularity of PPOs has continually increased since their introduction in the early 1980s.[3] The number of PPOs in the United States has grown almost ten-fold, from 115 in 1984 to 1036 in 1992. American Association of Preferred Provider Organizations, *PPO Growth (1984-1992)*, at 1 (June 1993). Similarly, in the five years between 1987 and 1992, the numbers of Americans participating in PPOs has risen from 12 million subscribers

Provider Organizations, 23 Inquiry 419, 420-21 (1986); H.E. Frech III & Paul B. Ginsburg, *Competition Among Health Insurers, Revisited*, 13 J. Health Pol. Pol'y & L. 279, 284 (1988); Thomas L. Greaney & Jody L. Sindelar, *An Assessment of the Anticompetitive Effects of Preferred Procider Organizations*, 24 Inquiry 384, 384-85 (1987).

[3] Notably, PPOs were not initially created by insurance companies, but rather by small independent firms. *See* Frech & Ginsburg, *supra*, at 289; *see also* Marci A. Firfer, *Direct Employer-Provider Contracting and ERISA Preemption: A Regulatory Loophole?*, 10 Fed'n Ins. & Corp. Couns. Q. 195, 203-04 (1990) (noting the rapid increase in PPOs since their "invention" in the early 1980s).

to 58 million. *Id.* Insurer-administered PPOs cover over 30 million individuals nationwide—54 percent of all current PPO subscribers. *Managed Care Digest, supra,* at 7.

The growth of PPOs is directly attributable to the benefits that PPOs provide to all participants and society as a whole. *See, e.g.,* Frech & Ginsburg, *supra,* at 284; Thomas L. Greaney & Jody L. Sindelar, *An Assessment of the Anticompetitive Effects of Preferred Provider Organizations,* 24 Inquiry 384, 384 (1987). In particular, PPOs have helped control overall health care costs by promoting price competition among providers. Because PPOs represent numerous health care recipients, they have substantial negotiating power. As a result, PPOs negotiate discounts in physician fees by a national average of 20 percent, and discounts in hospital costs averaging 17 percent nationally. *Managed Care Digest, supra,* at 36; Glenn A. Melnick et al., *The Growth and Effects of Hospital Selective Contracting,* 14 Health Care Mgmt. Rev. 57, 60 (1989).[4]

PPOs thus benefit patients greatly. PPO participants have lower out-of-pocket costs, yet they retain the freedom to choose physicians outside of the PPO network as well as providers within the network. *See, e.g.,* Dranove et al., *supra,* at 421; Greaney & Sindelar, *supra,* at 384-85.[5] Furthermore, because a PPO has greater resources than individual consumers, PPOs supply more information about providers and costs than is generally accessible

[4] PPOs promote the efficient use of medical resources through "utilization review," a mechanism whereby the PPO reviews the use of medical resources by hospitals and doctors to determine whether a procedure was necessary. Through utilization reviews, PPOs inhibit "moral hazards" *i.e.*, overconsumption and unnecessary use of medical resources that may occur because a health care recipient has a low "out-of-pocket" expense.

[5] The freedom to choose non-participating providers does not exist with most health maintenance organizations ("HMOs"). Unlike the case with PPOs, HMO subscribers who seek services from a non-participating provider must pay the full cost for those services.

to individuals. Where an individual consumer may not have the time or resources to investigate the quality or reputation of particular doctors, a PPO—through its selection of providers—can essentially serve as a "Good Housekeeping Seal of Approval" with respect to the competence of the health care provider. Thus, many PPO subscribers rely on the PPO's inclusion of a doctor in the network as an indication of that doctor's capabilities.

More generally, the increased information PPOs provide allows individual consumers to make more educated decisions about their particular health care needs. Greater consumer knowledge increases the competitiveness of the market, as providers are forced to respond to consumer needs. *See, e.g., Economic Report of the President* 139-40 (January 1993); Paul B. Ginsburg & Glenn T. Hammons, *Competition and the Quality of Care: The Importance of Information*, 25 Inquiry 108, 110-13 (1988). Claims to PPOs also involve far less paperwork than "traditional" health insurance.

PPOs benefit not only consumers, but also providers. For providers, participation in a PPO network guarantees a steady patient volume. Providers also have an incentive to strive for efficiency and quality care in order to compete with other providers and to meet the standards established by the PPO. Unlike the case with HMOs, however, PPO-participating providers need not reorganize their practice. Services are still provided on a "fee-for-service" basis, and providers do not assume the financial risk involved with HMO membership. *See, e.g.*, Ginsburg & Hammons, *supra*, at 109; Greaney & Sindelar, *supra*, at 385.[6] In addition, the turnaround time for claims is decreased because participating providers generally deal with fewer payor organizations.

[6] Because the payment an HMO makes to a provider is fixed, the risk that a particular patient or group may need more medical attention than usual, and thereby consume the doctor's resources, shifts to the doctors. *See, e.g.*, Frech & Ginsburg, *supra*, at 284; Greaney & Sindelar, *supra*, at 385-86.

PPOs also benefit society at large. PPOs have led to a reduction in the average hospital stay, the use of more outpatient procedures, a reduction in the inefficient and costly surplus of hospital beds, and an overall reduction in the number of unnecessary procedures. *See, e.g.*, Dranove et al., *supra*, at 420-21, 427-28; Lucy Johns, *Selective Contracting in California: An Update*, 26 Inquiry 345, 346-49 (1989). In the most comprehensive study of the effects of PPOs, which was conducted in California, researchers found that examination of different factors "all show that the [selective contracting] policy produced measurable cost containment." Johns, *supra*, at 345. For example, the average length of hospital stay for patients dropped by 2.9 percent in five years, and the rates of growth in gross medical expenses decreased significantly as well. *Id.* at 346-47. Furthermore, a number of services that can be conducted either on an inpatient or outpatient basis are increasingly performed without hospitalization. *Id.* Since the introduction of PPOs, the overall hospital expense per admission in California, the state with the largest number of PPOs in the nation,[7] has been consistently lower than that of the rest of the nation. Melnick et al., *supra*, 14 Health Care Mgmt. Rev. at 62. In 1986, the percent of per capita income spent on hospital services declined in California, while increasing in the rest of the nation. *Id.* Perhaps most importantly, Commentators estimate that the increase in the number of PPOs[8] has resulted in a 24-percent discount in medical services for PPO participants. *See* Dranove et al., *supra*, at 421.

Almost all health care commentators agree that results like those exhibited in California can be expected nationwide as PPOs increase. "[B]ecause PPOs can promote

[7] California has a total of 104 PPOs. Marion Merrell Dow, *Managed Care Digest: PPO Edition*, at 10 (1992).

[8] From 1984 to 1988, the number of PPOs in California increased from 37 to 72, and the number of enrollees increased from 430,000 to 16.8 million. Lucy Johns, *Selective Contracting in California: An Update*, 26 Inquiry 345, 351 (1989).

cost containment, improve market competitiveness, and produce positive externalities, public policies should promote the development of PPOs." Greaney & Sindelar, *supra*, at 389; *see also* Frech & Ginsburg, *supra*, at 289 ("public officials have generally applauded the degree of innovation in the private financing of health care"). The social utility of PPOs as effective health care delivery systems is therefore both quantifiable and substantial.

B. By Eliminating the Ability of Preferred Provider Organizations To Choose Providers in Their Plans, Any-Willing-Provider Statutes Destroy the Ability of PPOs To Control Health Care Costs.

Virginia's any-willing-provider statute, and similar laws of other states, prevent insurer-administered PPOs from selecting the provider-members of their PPO—the fundamental principle necessary for a PPO to operate effectively.[9] The application of the Virginia statute to insurer-administered PPOs creates "considerable inefficiencies in benefit program operation," *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987), thereby thwarting Congress's purpose in enacting ERISA to preempt employee benefit plans from state regulations. *See FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990) ("To require plan providers to design their programs in an environment of differing state regulations would complicate the admin-

[9] The Virginia statute states, in relevant part:

> Any . . . insurer [forming a PPO] shall establish terms and conditions that shall be met by a hospital, physician or type of provider listed in § 38.2-3408 in order to qualify for payment as a preferred provider under the policies or contracts. These terms and conditions shall not discriminate unreasonably against or among such health care providers. No hospital, physician or type of provider listed in § 38.2-3408 willing to meet the terms and conditions offered to it or him shall be excluded. Neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with providers or based on market conditions, or price differences among providers in different geographical areas, shall be deemed unreasonable discrimination. . . .

Va. Code Ann. § 38.2-3407 (Michie 1993).

istration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits.").

Opening PPOs to all providers that evince a willingness to meet the PPO's established terms and conditions diminishes the cost savings associated with such arrangements to the point where the economic incentives for both providers and subscribers to join a PPO are entirely dissipated. Too many health care providers in a PPO renders it incapable of guaranteeing a narrower group of chosen providers higher patient volume. Without any concrete benefit, hospitals and doctors are unable and unwilling to offer discounted rates. In the absence of lower rates, subscribers would not join a PPO.

Stated differently, limiting the number of providers in a PPO is essential to the PPO's ability to remain cost-effective. Studies show that there is an optimal number of providers for any given PPO in a geographical location. *See, e.g.*, Wyatt Company, *Report to Health Insurance Association of America*, at 15 (June 7, 1991) [hereinafter "*Wyatt Report*"]. Up to that number, a PPO will enjoy the economies of scale, and the increased negotiating power associated with size. These benefits will outweigh any administrative inefficiencies created by size, and would result in lower prices for consumers. Beyond that point, however, the marginal benefit of an additional provider exceeds the cost associated with increased membership. *Id.; see also* Glenn A. Melnick et al., *The Effects of Market Structure and Bargaining Position on Hospital Prices*, 11 J. Health Econ. 217, 229-30 (1992).[10]

In a 1991 study, researchers concluded that any-willing-provider statutes could increase administrative costs between 34 and 52 percent, and increase the cost of claims from 8.8 to 14.2 percent. *Wyatt Report*, at 4-5. These increased costs more than consume the hospital discounts

[10] In addition, without a competitive health care market, PPOs lack the incentives to ensure high-quality and low-cost service, or to provide accurate information to subscribers for use in making educated choices concerning health care.

of 17 percent and physician discounts of 20 percent that PPOs are able to derive on average. Thus, any-willing-provider statutes plainly destroy the ability of PPOs to contain health care costs.

Furthermore, the study noted that "reasonable" statewide provider selection criteria, such as those mandated by the Virginia statute, probably could not eliminate enough providers from the PPO to allow efficient utilization of selective contracting. *Id.* at 5. Rather, so many doctors and hospitals would have a "right" under the state statute to participate in the PPO that the costs savings necessary to justify entering into PPO agreements could not be attained. Thus, the existence of any-willing-provider statutes is fundamentally incompatible with that of insurer-administered PPOs.

The imposition of "reasonable" provider selection provisions impairs the effectiveness of PPOs because the criteria used by PPOs to screen providers is by necessity highly flexible and includes more than just so-called "objective" criteria.[11] PPOs must be free to make "arbitrary" judgments in selecting providers if they are to reach the optimal number of providers. For example, even if two providers are identical in quality and conventional price, a PPO that has reached its limit cannot be forced to allow both to participate. Mandating that both providers be allowed to join the PPO expands provider participation beyond the point of economic efficiency. Rather, a PPO must be allowed to choose between the two providers, even if on an "arbitrary" basis such as competitive bidding.

PPOs must also consider subjective factors as well as objective ones. These subjective criteria, such as percep-

[11] Such objective criteria include, in the case of hospitals, financial factors such as per diem rates, comparison to cost and charges at other hospitals in the service area. Quality selection criteria will often also include professional staff-to-patient ratio, malpractice history, percentage of staff physicians who are board certified, and accreditation status.

tions in the community, customers' relationships with hospital staff, financial stability and viability (including the cushion from charitab'e donations and tax base), and willingness to abide by rules of the managed care agreement, are not easily defined in the terms and conditions of a contract between the PPO and participating providers. Yet these factors are critical in determining which providers fit into the profile and philosophy of an individual PPO. *See, e.g.*, Ginsburg & Hammons, *supra*, at 110-13 (consumer opinions about a provider's quality of care in comparison to cost and its community reputation significantly affect individual decisions with respect to health care); Ezekiel J. Emanuel & Allan S. Brett, *Managed Competition and the Patient-Physician Relationship*, 329 New Eng. J. Med. 879, 880-82 (1993) (individual patient-physician relationships and continuity of care may affect health care choices even in managed competition). Any-willing-provider statutes severely constrain the ability of insurer-administered PPOs to select providers on the basis of these critical criteria, and to ensure that the providers continue to supply the type of care the PPOs seek to deliver.[12]

Not surprisingly, commentators and researchers uniformly criticize the application of any-willing-provider statutes to PPOs. *See, e.g.*, Greaney & Sindelar, *supra*, at 389 ("A primary blockade has been and continues to be state laws that prohibit selective contracting and that limit efficient contracting. We suggest that such laws be eliminated to allow for the growth of PPOs."); *Wyatt Report*, *supra*, at 5 ("th[e] legislative mandate [in any-willing-provider statutes] would eliminate the value of that PPO to the community"). Indeed, the purpose of these statutes is directly contrary to the principles of selective

[12] The quality of care maintained by a provider after the provider enters the network is important and cannot be defined in terms of the contract. Although the PPO may terminate its contract with a provider if the quality diminishes, a PPO would rather exclude providers it deems unacceptable from participation in the PPO in the first place. Dranove et al., *supra*, at 428.

contracting which underlie the effectiveness of PPOs. Thus, any-willing-provider statutes frustrate the development of PPOs as a mechanism for combatting escalating health care costs.

II. INSURANCE COMPANY ADMINISTRATION OF A PREFERRED PROVIDER ORGANIZATION DOES NOT CONVERT A PPO INTO THE "BUSINESS OF INSURANCE".

Notwithstanding the social value of PPOs and the dangers presented by any-willing-provider statutes, the Fourth Circuit erroneously held that insurer-administered PPOs must comply with the Virginia statute because it is not preempted by ERISA. That decision misinterpreted the meaning of the phrase "business of insurance" and, in the process, created several conflicts with this Court's prior decisions and with decisions from other circuits.

ERISA preempts all state laws that "relate to any employee benefit plan." 29 U.S.C. § 1144(a) (1988). Any state statute that "regulates insurance," however, is saved from preemption. *Id.* § 1144(b)(2)(A). This Court has stated that whether a statute "regulates insurance" is guided by the same criteria used to determine whether an entity is engaged in the "business of insurance," as that phrase is used in the McCarran-Ferguson Act, 15 U.S.C. § 1011 (1988). *See, e.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48-49 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985). In interpreting these terms, the Court has recognized that Congress intended ERISA preemption to be very broad. *See, e.g., FMC Corp. v. Holliday*, 498 U.S. 52, 59 (1990); *Metropolitan Life*, 471 U.S. at 739; *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97-98 (1983).[13]

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[13] The legislative history confirms ERISA's wide scope of preemption. As stated by one Representative during the House debates:

> I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefit plans.

Selective contracting by PPOs is part of the "business of insurance companies," not the "business of insurance." *See, e.g., Hartford Fire Ins. Co. v. California*, 113 S. Ct. 2891, 2902 (1993); *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 233 (1979). It is the mechanism by which the PPO controls administrative costs and procures the efficient delivery of health care. Just as agreements made with retail pharmacists are unrelated to the "business of insurance" because pharmacists are "parties wholly outside the insurance industry," agreements made with hospitals, doctors, and other health care providers likewise should not be considered the "business of insurance." *See Royal Drug*, 440 U.S. at 231-33; *see also Hartford Fire Insurance Co.*, 113 S. Ct. at 2902.

A recent decision by this Court highlights the Fourth Circuit's error. As was recognized in *Hartford Fire Insurance Co.*, " 'the business of insurance' should be read to single out one *activity* from others, not to distinguish one *entity* from another." *Id.* at 2901 (emphasis added). In contravention of this mandate, the Fourth Circuit relied on Aetna's status as an insurance entity rather than focusing on the pertinent activity. The Fourth Circuit thus "draws a broad and illogical distinction between benefit plans that are funded by [non-insurance companies] and those that are insured by regulated insurance companies." *EMC Corp.*, 498 U.S. at 65 (Stevens, J., dissenting). The disparate treatment of insurer-administered PPOs is further evidence of the "patchwork scheme of regulation" sought to be avoided under ERISA to prevent "considerable inefficiencies in benefit program operation."

With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation.

120 Cong. Rec. 29197 (1974) (remarks of Rep. Dent); *see also id.* at 29933 (remarks of Sen. Williams) ("[ERISA preemption] is intended to apply in its broadest sense to all actions of State or local governments"); H.R. Rep. No. 1785, 94th Cong., 2d Sess. 47 (1977) ("[T]he Federal interest and the need for national uniformity are so great that enforcement of state regulation should be precluded.").

Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 11 (1987).[14]

Moreover, in considering whether a statute regulates the "business of insurance," this Court has said that the activity regulated must satisfy three requirements:

> *first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.

Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129 (1982), *quoted in Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743 (1985). All three factors must be satisfied for a regulated activity to be considered the "business of insurance." The Fourth Circuit's decision, however, contorts these three factors in order avoid ERISA preemption. In so doing, the lower court has impermissibly re-written the meaning of the "business of insurance."

Unlike insurance contracts, PPO agreements with health care providers do not "transfer[] or spread[] a policyholder's risk." *Pireno*, 458 U.S. at 129; *accord Metropolitan Life*, 471 U.S. at 743. A health insurer contracts to pay for an insured's medical services in return for a fixed premium. That premium is calculated by equalizing the known, but unpredictably distributed, medical costs incurred by the consumers (policyholders) within the risk pool. *See, e.g.*, Frech & Ginsburg, *supra*, at 279. Thus, through actuarial science, health insurers are able to respond to the random catastrophes of individual life precisely because, on a large scale, the frequency of such

[14] *See also Travelers Ins. Co. v. Cuomo*, No. 93-7132L, slip op. at 29 (2d Cir. Oct. 25, 1993) ("Congress intended that ERISA's preemption provision would clear the field of any state law interfering with benefit plans . . . . The more expansively the saving clause is read, the more deeply it cuts into the preemption, a result that would render the entire scheme unworkable.").

events becomes reasonably predictable. *See generally* Robert E. Keeton & Alan I. Widiss, *Insurance Law* 12-13 (1988).

A PPO's dealings with health providers do not serve the role of "risk pooling." In their interactions with providers, PPOs do not categorize risks, predict their frequency, or determine coverage for certain risks. The choice of providers for participation in a PPO is wholly unrelated to the calculation of risk. Similarly, neither the number of providers participating in a PPO nor the terms and conditions imposed on participating providers will affect the probability of a health care claim for which the PPO must pay. *See* Marci A. Firfer, *Direct Employer-Provider Contracting and ERISA Preemption: A Regulatory Loophole?*, 40 Fed'n Ins. & Corp. Couns. Q. 195, 216 (1990) ("a PPO is *not* a traditional indemnity insurance plan" (emphasis in original)); *id.* at 235 ("[T]he concept of insurance typically includes both the accumulation and distribuiton of a fund, and the transfer of risk. A PPO does neither."). Rather, these dealings are between the PPO and providers, not the PPO and individual health care recipients or their payers.

Thus, the Fourth Circuit's overly expansive definition of a "policyholder's risk" is in clear error. App. 9a-10a. Treating all statutes relating to the type and cost of treatment available to a subscriber as within the defiintion of a "policyholder's risk" would subject almost all business decisions made by insurer-administered PPOs to state law. Accordingly, the Virginia statute does not satisfy the first criteria set forth by this Court because selective contracting does not have "the effect of transferring or spreading a policyholder's risk." *Pireno*, 458 U.S. at 129; *accord Metropolitan Life*, 471 U.S. at 743.

The statute also fails the second prong of the *Pireno* test, because it is not "an integral part of the policy relationship." *Pireno*, 458 U.S. at 129. In *Royal Drug*, this Court recognized that only agreements between the insurer and the insured were a part of the policy relation-

ship. *Royal Drug*, 440 U.S. at 215-16. "So long as th[e] promise [made between the subscriber and the intermediary] is kept, policyholders are basically unconcerned with arrangements made between [the intermediary] and participating [providers]." *Id.* at 214.

Finally, the Virginia statute fails the third prong of the *Pireno* test. As noted, the practice of organizing and administering PPOs was initially undertaken by third-party administrators and small investment companies, not insurance companies, *see* Frech & Ginsburg, *supra*, at 289, and the "insurance industry" owns only 36 percent of the existing PPOs nationwide. *See Managed Care Digest*, *supra*, at 7. As such, it is plainly meritless to contend that "the [PPO] practice is limited to entities within the insurance industry." *Metropolitan Life*, 471 U.S. at 743. Accordingly, because PPOs meet none of the Court's cirteria for determining what constitutes the "business of insurance," the Fourth Circuit incorrectly held that the any-willing-provider statute was "saved" from ERISA preemption.

The Fourth Circuit's reasoning that the statute regulated the business of insurance simply because "[i]t is part of a comprehensive code regulating accident and sickness insurance," App. 9a, directly conflicts with the Fifth Circuit's decision in *Tingle v. Pacific Mutual Insurance Co.*, 996 F.2d 105 (5th Cir. 1993).[15] In *Tingle*, the Fifth Circuit stated that "the mere fact that a statute is part of a comprehensive state insurance code will not exempt it from preemption." *Id.* at 109.[16] In this respect as well,

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[15] In addition to *Tingle*, the Fourth Circuit's decision conflicts with *Ticor Title Insurance Co. v. FTC*, 998 F.2d 1129 (3d Cir. 1993), as well as a decision from its own circuit, *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981). *See* Petition for Writ of Certiorari filed by Aetna at 22-24, 25-26.

[16] *See also Hansen v. Continental Ins. Co.*, 940 F.2d 971 (5th Cir. 1991) (ERISA preemption of statute included in the Texas Insurance Code); *Ramirez v. Inter-Continental Hotels*, 890 F.2d 760, 763-64 (5th Cir. 1989) (same); *Anschultz v. Connecticut*

the Fourth Circuit erred and created an intercircuit conflict that can only be resolved by this Court.

III. CURRENT CONSIDERATION BY CONGRESS OF HEALTH CARE REFORM DOES NOT ELIMINATE THE NEED FOR THE COURT TO REVIEW THIS CASE.

The present consideration by Congress of health care reform is not a basis for denying certiorari. Indeed, that circumstance militates in favor of granting the writ of certiorari so that the important issues of state-federal relations posed can be clarified as new health care arrangements are considered and potentially implemented. Even if President Clinton's health care reform proposal were adopted *today*, the ill effects of the Fourth Circuit's erroneous decision would remain. Accordingly, resolution of this case by the Court is necessary because: (1) PPOs would continue to exist under most of the proposed plans, and the question as to whether federal law preempts state regulations such as any-willing-provider statutes will remain; (2) even if adopted this year, none of the current health care plans under consideration would take effect for quite a long time, and calls for interim measures to control health care costs during the transition will exacerbate the need to vest insurance companies with the ability to choose providers; and (3) the Fourth Circuit decision creates unnecessary confusion as to this Court's jurisprudence concerning the "business of insurance."

First, and foremost, President Clinton's proposal, like many others, calls for the establishment of regional and corporate health alliances, whereby "[e]ach alliance offers a menu of plans, including a traditional fee-for-service arrangement, *preferred provider organizations* and health maintenance organizations." The White House, *Health Security Preliminary Plan Summary* 19 (1993) (emphasis added); *accord id.* at 23. Furthermore, none of the major proposals currently under consideration contemplate

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General Life Ins. Co., 850 F.2d 1467 (11th Cir. 1988) (ERISA preemption of statute included in the Florida Insurance Code).

amending ERISA's insurance savings clause in a manner which would affect the question presented by this case. *See, e.g., Clinton Administration Description of President's Health Care Reform Plan, "American Health Security Act of 1993"*, Health L. Rep. (BNA) S-24, at 71-72 (Sept. 16, 1993).[17] Thus, PPOs would still compete in any new health care plan, but whether they would be subject to state insurance laws would, it seems, still be governed by the ERISA provisions at issue here. Accordingly, the importance of resolving this issue extends beyond the passage of any health care reform package.[18]

In addition, health care reform, even if adopted by Congress immediately, will not be implemented until at least 1997. In fact, most commentators doubt that any health care plan will be implemented much before the turn of the millennium. *See, e.g., Two Plans and Where They Might Lead*, Wall St. J., Sept. 23, 1993, at A8; *Shouting Matches: Six Areas of Dispute*, Newsweek, Oct. 4, 1993, at 49. And, for any transition period, the Presi-

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[17] *See also, e.g., Health Care: Clinton's Plan and the Alternatives*, N.Y. Times, Oct. 17, 1993, at 22; *Two Plans and Where They Might Lead*, Wall St. J., Sept. 23, 1993, at A8; *Shouting Matches: Six Areas of Dispute*, Newsweek, Oct. 4, 1993, at 49 (describing the main alternative proposals to the Clinton plan). The only bill that would affect state regulation of PPOs is H.R. 3222, introduced by Representative Cooper. Recognizing the problems posed by any-willing-provider statutes, the Cooper bill provides that "[a] State may not prohibit or limit a network plan from limiting the number of participating providers." H.R. 3222, § 1222(a)(4). This bill, however, is generally considered unlikely to pass, and none of the other proposals contemplate a similar amendment.

[18] In addition, the Clinton proposal, and the main alternatives, all rely on managed competition to drive down costs. "The Health Security plan controls rising costs and improves the quality of health care by enlisting the power of a competitive market and empowering consumers to make choices that suit their needs." The White House, *Health Security Preliminary Plan Summary* 14 (1993). Because any-willing-provider statutes interfere with market competition, these plans further support the view that PPOs and selective contracting programs constitute sound public policy.

dent has proposed controlling escalating health care costs by tightly regulating insurance premium increases. *See* Dana Priest, *Insurance Curbs Asked for Interim*, Wash. Post, Sept. 27, 1993, at A1. To maintain proper financial stability during this time, insurance companies must be able to administer programs like PPOs in a manner which would contain costs.

Finally, the Fourth Circuit's decision misapplies and unnecessarily confuses the jurisprudence defining the "business of insurance." This definition applies to ERISA preemption independent of the health care proposal, and is also employed in the McCarran-Ferguson Act. Thus, cases such as this, distinguishing between the "business of insurance" and the "business of insurance companies," are important regardless of their relation to health care reform legislation.

CONCLUSION

For all of the foregoing reasons, the Court should grant the petition of Aetna Life Insurance Company and Aetna Health Management, and set the case for plenary review.

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No. 93-510

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,
Petitioners,

v.

STUART CIRCLE HOSPITAL CORPORATION,
Respondent.

On Petition For Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

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REPLY BRIEF OF PETITIONERS

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REPLY BRIEF

Aetna Life Insurance Company and Aetna Health Management (collectively "Aetna") petitioned for a writ of certiorari on the question whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, preempts a Virginia "any willing provider" law that mandates the health care providers that must be included in a preferred provider organization ("PPO"). In its petition, Aetna demonstrated the extraordinary importance of this question: Any willing provider laws undermine the fundamental logic of the PPO, a market-driven mechanism for the efficient delivery of medical care, and thereby increase significantly the cost of health care for employee benefit plan participants. The several briefs of *amicus curiae* submitted in support of Aetna attest to the vital nature of the question presented. Aetna showed also that the Fourth Circuit's decision in this case, holding that the Virginia law is saved from ERISA preemption as a law that regulates insurance, is directly contrary to Supreme Court authority and inconsistent with the decision of at least one other court of appeals.

Respondent Stuart Circle Hospital Corporation ("Stuart Circle") does not dispute the significance of the question presented, or the profound adverse consequences that any willing provider laws create for benefit plan participants.[1] Rather, Stuart Circle uses

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[1] Stuart Circle does argue that Aetna's demonstration of the exceptional harm caused by the Virginia any willing provider law is "irrelevant" if the law is not preempted. Opp. at 11 n.9. But this is a petition for writ of certiorari, for which the importance of the question presented is very much relevant. S.

its brief in opposition principally to restate the Fourth Circuit's conclusions. Aetna has demonstrated already how the Fourth Circuit misapplied this Court's case law. Stuart Circle's brief adds little new.

Like the Fourth Circuit, Stuart Circle asserts that the issue in this case is controlled by *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). Like the Fourth Circuit, Stuart Circle ignores the import of *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). *Metropolitan Life* simply does not speak to the issue in this case, while *Royal Drug* addresses it squarely.

Metropolitan Life concerned a state statute that regulated the content of health insurance policies directly, mandating that these policies provide coverage for the treatment of certain illnesses and injuries. That "mandatory benefit" law was, in the Court's view, a law regulating the "business of insurance." 471 U.S. at 743. *Royal Drug*, by contrast, like the present case, involved the contractual relationship between an insurance company and service providers. That contractual relationship affected policy holders only indirectly by dictating *who* would provide covered services; the service arrangements had no effect on the services covered by the insurance policy. This Court held that such service arrangements are not the "business of insurance."[2] 440 U.S. at 216-17. It

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Ct. Rule 10.1(c). Stuart Circle does not dispute the importance of the question here. Moreover, that any willing provider laws are harmful to plan participants, and subject plan sponsors to inconsistent regulation, obviously is relevant to the question whether this is the type of law ERISA is intended to preempt.

[2] The Third Circuit's decision in *Ticor Title Ins. Co. v. FTC*,

follows *a fortiori* that if that practice does not constitute the "business of insurance," a statute mandating who must provide covered services (a "mandatory provider" law) is not a law regulating insurance.

Royal Drug is still good law, as much as Stuart Circle would like to ignore that decision. *See United States Dept. of Treasury v. Fabe*, 113 S. Ct. 2202, 2209 (1993) (*Royal Drug* involved "ancillary activities" with insufficient connection to the obligations of the insurance contract); *Hartford Fire Ins. Co. v. California*, 113 S. Ct. 2891, 2902 (1993) ("agreements that insurance companies ma[k]e with parties wholly outside the insurance industry, . . . such as the retail pharmacists involved in *Royal Drug* . . . are unlikely to be about anything that could be called 'the business of insurance,' as distinct from the broader 'business of insurance companies' ") (internal quotations and citations omitted). Nothing in *Metropolitan Life* is inconsistent with *Royal Drug* or dictated the result reached by the Fourth Circuit. *Metropolitan Life* con-

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998 F.2d 1129 (3d Cir. 1993), stands also for the proposition that insurance company service arrangements are not the "business of insurance." In that regard, *Ticor* is consistent with *Royal Drug* and inconsistent with the Fourth Circuit opinion here. Stuart Circle contends that *Ticor* is inapposite because this case, unlike *Ticor*, involves a statute that "regulates the contents of an insurance contract." Opp. at 8. But the Virginia law does not regulate insurance contracts, it regulates service arrangements between insurance companies and service providers. These arrangements affect the terms of insurance contracts, but so too do the title search and examination services at issue in *Ticor*. The real distinction between this case and *Ticor* is that the Third Circuit followed the rule of *Royal Drug*, while the Fourth Circuit did not.

cerned a mandatory *benefit* law; Virginia Code § 38.2-3407 is a mandatory *provider* law.[3] Mandatory provider laws were not at issue in *Metropolitan Life*.

Stuart Circle seeks to avoid this fact by making a holding out of prefatory language in *Metropolitan Life*. By way of introduction to the problem presented in *Metropolitan Life*, the Court explained that mandatory benefit laws are one species of a larger family

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[3] It is unclear whether Stuart Circle understands how Virginia Code § 38.2-3407 works. Stuart Circle contends that the statute would not affect insurance companies that simply administer self-funded employee benefit plans. Opp. at 3 n.2. The statute plainly applies to insurance companies that "administer" a PPO, Va. Code § 38.2-3407(A), regardless of whether the employee benefit plan itself might be considered an insurer.

Stuart Circle also seeks to soften the blow of the Virginia statute by arguing that a PPO network with reasonable terms and conditions *may* exclude providers willing to meet those terms. Opp. at 4 n.4. The plain language of Virginia Code § 38.2-3407 is to the contrary. *HCA Health Services of Va., Inc. v. Metropolitan Life Ins. Co.*, 752 F.Supp. 202 (E.D. Va. 1990), *appeal dismissed*, 957 F.2d 120 (4th Cir. 1992), which Stuart Circle cites, is consistent with this plain language.

Stuart Circle accuses Aetna of failing to reproduce in its petition sections of Virginia Code § 38.2-3407 relevant to this case. Opp. at 2. The only section not reproduced in Aetna's petition to which Stuart Circle makes reference is section 38.2-3407(E). *Id.* Stuart Circle fails to explain the import of this provision to the present case. Section (E) merely explains that an insurance policy offering health coverage through a PPO is a policy that specifies the amount of insurance coverage for treatment by preferred and nonpreferred providers. It is a non-controversial definitional section without relevance to the issue presented here. Stuart Circle might as well have accused Aetna of failing to reproduce all of ERISA's definitional provisions. The rules of this Court require reproduction only of those statutory provisions "involved in the case." S. Ct. Rule 14.1(f).

of state regulation. 471 U.S. at 729. These laws include mandatory provider provisions. *Id.* From this passing reference, Stuart Circle concludes that *Metropolitan Life* resolves the issue in this case. Opp. at 7, 13, 15.

To read *Metropolitan Life* as resolving an issue clearly not before the Court is contrary to established principles of jurisprudence.[4] It also would expand *Metropolitan Life* to overrule *Royal Drug sub silentio*, or to confine the applicability of *Royal Drug* to non-ERISA cases. These conclusions are plainly contradicted by the reaffirmation of *Royal Drug* in *Fabe* and *Hartford Fire* and, more importantly, by *Metropolitan Life* itself, an ERISA case that cites *Royal Drug* for the definition of the "business of insurance." 471 U.S. at 743. *Metropolitan Life* and *Royal Drug* are completely compatible. The two cases present a rational distinction between mandatory benefit and mandatory provider laws. The former regulate the business of insurance; the latter do not.

Stuart Circle's recapitulation of the Fourth Circuit's argument extends to its attempt to distinguish *Royal Drug*. Stuart Circle repeats the Fourth Circuit's mistake that the choice of provider is a "benefit" and part of the insured risk—unlike the choice of pharmacists in *Royal Drug*—and therefore falls within the ambit of *Metropolitan Life*. Opp. at 16-17. This is no distinction at all. Stuart Circle merely mimics the

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[4] *See Cohens v. Virginia*, 19 U.S. 264, 399-400 (1821) ("The question actually before the Court is investigated with care and considered in its full extent. Other principles which may serve to illustrate it, are considered in their relation to the case decided, but their possible bearing on all other cases is seldom completely investigated.").

Fourth Circuit's conclusion that choice of physician or hospital is an "important" component of health insurance.[5] Choice of physician may be important to benefit plan participants, but this does not answer the question whether a limitation on choice of providers constitutes the "business of insurance." On this point, *Royal Drug* is unequivocal: a restriction on the providers of services without a concomitant restriction on services provided is not the "business of insurance."

At base, the Fourth Circuit's, and consequently Stuart Circle's, conclusion rests on nothing more than an intuitive feeling that choice of doctors and hospitals is different from choice of pharmacists and therefore more appropriately the subject of state regulation. There are obvious differences between these choices, and a state legislature understandably might be more concerned with one than the other, but ERISA preempts all such regulation unless it regulates the "business of insurance." Neither the Fourth Circuit nor Stuart Circle points to any distinction between a contractual arrangement limiting the choice of pharmacists and an identical arrangement limiting the choice of doctors and hospitals that is relevant to the question whether a limitation of either choice is the "business of insurance." The "business of insurance" question certainly does not turn on whether one practice is more "important" than another in the view of a state legislature.

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[5] Stuart Circle contends also that the limitation of providers available in a PPO affects the "quality" of care available to insureds. Opp. at 4. There is absolutely nothing in the record in this case to support this assertion.

To supplement its fruitless distinction of *Royal Drug*, Stuart Circle argues that this Court's recent decision in *Fabe* has rendered *Royal Drug* irrelevant to ERISA. Opp. at 17-19. In fact, *Fabe* fully supports the conclusion that laws that regulate insurance company service arrangements do not regulate the "business of insurance." *Fabe* involved a state law that regulated directly the performance of insurance contracts (i.e., the payment of benefits to insureds) in bankruptcy, and therefore regulated the "business of insurance." The Court distinguished *Royal Drug*, which involved only insurance company "ancillary activities." 113 S. Ct. at 2209. Any "indirect effects" on insurance policies from the service arrangements at issue in *Royal Drug*, the *Fabe* Court explained, are insufficient to make the practice the "business of insurance." *Id.* at 2212. The same necessarily is true of the PPO arrangements at issue here.

Stuart Circle purports to find support for its position from the distinction drawn in *Fabe* between the first and second clauses of section 2(b) of the McCarran-Ferguson Act. The first clause addresses state laws enacted "for the purpose of regulating the business of insurance," while the second clause exempts from federal antitrust regulation the "business of insurance." 15 U.S.C. § 1012(b). The *Fabe* Court explained that the scope of the first clause necessarily is broader than that of the second. 113 S. Ct. at 2210. Stuart Circle contends that the ERISA insurance savings clause is the equivalent of the first clause of the McCarran-Ferguson Act and, therefore, that *Royal Drug*, which dealt with the second clause, is irrelevant.

Stuart Circle reads far too much into *Fabe* and ignores the logic of that opinion. While distinguishing between laws enacted "for the purpose of regulating the business of insurance," and the "business of insurance," the Court did not ignore—as it could not—that the phrase "business of insurance" appears in both clauses. If a practice does not constitute the "business of insurance" under the second clause of the McCarran-Ferguson Act, then a law directed solely at that practice cannot possibly be law that has "the purpose of regulating the business of insurance" under the first clause. *Royal Drug*, which the Court reaffirmed in *Fabe*, teaches that the insurance company service arrangements at which Virginia Code § 38.2-3407 is directed are not the "business of insurance."

In addition, Stuart Circle's attempted identity between the first clause of McCarran-Ferguson—which protects state laws enacted "*for the purpose of* regulating the business of insurance," 15 U.S.C. § 1012(b) (emphasis added)—and the ERISA insurance savings clause—which saves from ERISA preemption laws "which regulate[] insurance," 29 U.S.C. § 1144(b)(2)(A)—simply does not work. The Court in *Fabe* based its distinction between the first and second clauses of the McCarran-Ferguson Act on the "purpose of" language. *See* 113 S. Ct. at 2210 (laws enacted "for the purpose of " regulating the business of insurance possess the "end, intention, or aim" of regulating the business of insurance and therefore encompass more than just the "business of insurance") (internal quotations and citation omitted). That language is missing from the ERISA insurance savings clause, which excepts from ERISA preemption

only laws that actually *do* "regulate the business of insurance."

That *Royal Drug* and the second clause of the McCarran-Ferguson Act (which addresses the "business of insurance") retain their relevance to the ERISA insurance savings clause is absolutely certain from both *Fabe* and *Metropolitan Life*, upon which Stuart Circle builds its entire argument. The *Fabe* Court explained that *Royal Drug* and *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982), involved the second clause of the McCarran-Ferguson Act. 113 S. Ct. at 2209. In *Metropolitan Life*, the Court adopted explicitly to its application of the ERISA insurance savings clause the three-part test developed in *Pireno*, and the Court cited *Royal Drug* in the same passage. 471 U.S. at 743. The *Royal Drug/Pireno* analysis thus controls in ERISA preemption cases.

Stuart Circle ends its brief with a repetition of the Fourth Circuit's observation that the policy behind the Virginia any willing provider law is "a concern of the legislature, not the judiciary." Opp. at 19, 20. This is nothing but question begging. If ERISA preempts Virginia Code § 38.2-3407, then the choice to mandate PPO providers is certainly *not* left to the Virginia legislature. The question presented here is whether the Virginia statute is the type of law ERISA preempts. The policy this Court would enforce in answering this question is the basic policy behind ERISA preemption, precluding what Congress judged to be the deleterious effects of state interference with employee benefit plans.[6]

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[6] Stuart Circle also raises the specter of health care reform.

CONCLUSION

For the foregoing reasons and those set forth in Aetna's petition for writ of certiorari, the Court should grant this petition and set the case for plenary review.

November 4, 1993 Respectfully submitted,

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Opp. at 20 n.16. That long-term process should present no obstacle to review of the question presented by this petition. It is impossible to predict what, and when, health care reform will come, or how it might affect any willing provider laws. These laws are in place *now* inhibiting immediate solutions to rising health care costs. Indeed, virtually every health care reform proposal is based on some form of managed care, underscoring the importance of the mechanisms with which state laws now interfere. *See also* Brief *Amicus Curiae* of the Travelers Insurance Company and Blue Cross and Blue Shield of the National Capital Area at 18-20.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,
Petitioners,

v.

STUART CIRCLE HOSPITAL CORPORATION,
Respondent.

On Petition for Writ of Certiorari to the
United States Court of Appeals for the Fourth Circuit

RESPONDENT'S OPPOSITION TO MOTIONS FOR LEAVE TO FILE BRIEFS *AMICUS CURIAE*

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Respondent's Opposition to Motions for Leave to File Briefs *Amicus Curiae*

Respondent Stuart Circle Hospital Corporation ("Stuart Circle") opposes the Motions for leave to file briefs *amicus curiae* in support of the Petition for writ of certiorari submitted by Aetna Life Insurance Company and Aetna Health Management (collectively, "Aetna") and, pursuant to Rule 21.4, respectfully

shows the Court the following reasons why the Motions should be denied.[1]

ARGUMENT

1. The proposed *amici* include two members of Aetna's newly formed insurance lobbying group (Metropolitan, Travelers); two insurance industry trade associations (ACLI, HIAA); three health care groups whose members include insurance companies (GHAA, AAPPA, AMCRA); a health benefit insurer (BC/BS NCA); a business group from Connecticut, where Aetna and many other insurers are domiciled (CBIA); and two employee benefit groups whose plan sponsors purchase insurance (APWWP, NCCMP). Only the last two entities arguably meet the traditional definition of a "friend of the court," as opposed to an advocate of partisan interests. *See New England Patriots Football Club, Inc. v. University of Colorado*, 592 F.2d 1196, 1198 n.3 (1st Cir. 1979).

Regardless, the briefs tendered for filing by the proposed *amici*, without exception, merely restate points and authorities already fully aired by Aetna in its

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[1]Motions have been filed on behalf of these entities:

American Council of Life Insurance ("ACLI")
Association of Private Pension and Welfare Benefit Plans ("APWWP")
Connecticut Business and Industry Ass'n ("CBIA")
Group Health Ass'n of America, Inc.("GHAA")
Health Insurance Ass'n of America ("HIAA"), American Ass'n of Preferred Provider Ass'ns ("AAPPA"), and American Managed Care and Review Ass'n ("AMCRA")
Metropolitan Life Insurance Co. ("Metropolitan")
National Coordinating Committee for Multiemployer Plans ("NCCMP")
The Travelers Insurance Co. ("Travelers") and Blue Cross and Blue Shield of the National Capital Area ("BC/BS NCA")

Petition; they do not independently "bring[] relevant matter to the attention of the Court... ." Rule 37.1. This kind of redundant advocacy is disfavored because it "simply burdens the staff and facilities of the Court...." *Id.*

2. In arguing that they should be granted leave to file briefs in support of the Petition, the proposed *amici* misconstrue the plain meaning and exaggerate the effect of the Virginia statute at issue in this case. Like Aetna, the *amici* erroneously contend that "[t]he Virginia law... bars insurers from excluding any provider willing and able to meet the PPO's membership requirements, regardless of need." Motion of NCCMP at p. 3;[2] Pet. at 4. The Virginia statute mandates no such thing; in pertinent part, it permits even "willing" providers to be excluded if the insurer establishes terms and conditions which do not "discriminate unreasonably against or among such health care providers." Va. Code § 38.2-3407(B). Whether an insurer such as Aetna has satisfied its obligations under the statute is to be decided on a case-by-case basis. The effect of the Fourth Circuit's decision below is simply to allow Stuart Circle's state law claim to be decided on the merits, as it should be, subject to normal review by an appeals court. The views of the proposed *amici* flow from either a basic misunderstanding of this case or a design to overstate its true significance.

3. The Fourth Circuit in this case found that the Virginia statute was enacted to protect policyholders from overreaching by insurers. App. 10a, 12a. It is noteworthy, but not surprising, that the proposed *amici* never once take notice of this critical aspect of

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[2] *See, e.g.*, Motion of APPWP at p. 2 ("By requiring PPOs to include 'any willing' medical provider in the panel,....").

the decision below. The commercial health insurance industry and its allies for many years have resisted the consumer protection initiatives of local insurance regulators on the theory that ERISA trumps the States' authority in this area.[3] In requesting the Court to hear this case, the proposed *amici* embrace a shop-worn public policy argument that this Court rejected nearly a decade ago in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), and which Aetna erroneously attempts to resurrect here. Simply put, Aetna and its *amici* argue that laws like Va. Code § 38.2-3407 should be pre-empted by ERISA because they indirectly affect benefit plans which purchase insurance by imposing regulatory requirements upon insurers.[4] The Court in *Metropolitan Life*, however, held that Congress intended ERISA's insurance saving

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[3]In its brief to this Court in support of the (unsuccessful) insurance petitioner in *Metropolitan Life*, *infra*, one of the proposed *amici* here stated that

> ". . . HIAA and its member companies have consistently opposed the enactment of state mandated health benefit laws on the grounds that these laws restrict design flexibility, inhibit uniformity in benefit packages, increase costs to employers and employees and promote self-funding of benefit plans."

Brief *Amicus Curiae* of Health Insurance Association of America in Support of Jurisdictional Statements (Nos. 84-325 and 84-356, filed Sept. 29, 1984), at 3.

[4]*See, e.g.*, Pet. at 10-15; Brief of APPWP at 13 ("This Court therefore should give full effect to ERISA's broad preemption provision to relieve plans and plan sponsors from this form of costly and inefficient state interference.").

clause to operate broadly to preserve the States' lawmaking power over insurance, even if the effect is indirectly to regulate plans which purchase insurance. *Metropolitan Life*, 471 U.S. at 747. The Court explicitly stated that if national plans enter into local markets to purchase insurance, any "disuniformities" created by variance among state laws

> ...are the inevitable result of the congressional decision to "save" local insurance regulation. Arguments as to the wisdom of these policy choices must be directed at Congress. (*Id.*).

The public policy argument of the proposed *amici* thus has no helpful or persuasive value in this or any other judicial forum. As the Fourth Circuit aptly said, the wisdom of the Virginia statute "is a concern of the legislature, not the judiciary." App. 12a.

CONCLUSION

The Motions for leave to file briefs *amicus curiae* should be denied.

Respectfully submitted,

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November 8, 1993

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